General Information	Preliminary		
Name of Hospital:		Medicare Provide	er Number:
Javon Bea Hospital-Childre	ens		14-0239
Street:		Medicaid Provide	
2400 North Rockton City:	State:	Zip:	18009
Rockford	Illinois	Ζιμ.	61103-3655
Period Covered by Statement:	From:	To:	
Type of Control	07/01/2022		06/30/2023
Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
Church	Individual	State	Township
XXXX Corporation	Partnership	City	Hospital District
Other (Specify)	Corporation	County	Other (Specify)
Type of Hospital			_
General Short-Term	Psychiatric		Cancer
General Long-Term	Rehabilitation	XXXX XXXX	Other (Specify) Children's Hospital
Health Care Program	(A Separate Report Must E	Be Filled Out For Each Distinc	t Part Unit)
XXXX Medicaid Hospital	Medicaid Sub II Rehab		
Medicaid Sub I Psych	Medicaid Sub II Other	1	<u> </u>
NOTE: Intentional Misrepresentati By Fine And / Or Imprisonn	on Or Falsification Of Any Information I nent Under Federal Law	n This Cost Report May Be Pu	unishable
CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDER(S):		
Sheet and Statement of Revenue an for the cost report beginning 07/	d the above statement and that I have exa d Expense prepared by (Provider name(s) 01/2022 and ending 06/30/2023 and books and records of the provider in ac	and number(s)) Javon d that to the best of my knowled	Bea Hospital-Childrens 18009 Ige and belief, it is a true, correct and
Prepared by (Signed):		Signed (Officer or Adr	ninistrator of Provider(s)):
Name (Typewritten)		Name (Typewritten)	
Title	Date	Title	
Firm		Date	
Telephone Number		Telephone Number	
Email Address		Fmail Address	

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18009
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

					Total	Percent		Number Of	Average
					Inpatient	Of	Number	Discharges	Length Of
			Total	Total	Days	Occupancy	Of	Including	Stay By
	Inpatient Statistics	Total	Bed	Private	Including	(Column 4	Admissions		Program
Line	inpatient otatistics	Beds	Days	Room	Private	Divided By	Excluding	Excluding	Excluding
No.		Available	Available	Days	Room Days	_	Newborn	Newborn	Newborn
140.	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	Adults and Pediatrics	4	1,460	(0)	57	3.90%	(0)	1,763	6.05
	Psych	<u> </u>	1,100		01	0.0070		1,700	0.00
	Rehab								
	Other (Sub)								
	Intensive Care Unit							************	***********
	Coronary Care Unit								
	NeoNatal ICU	52	18,980		10,616	55.93%			
	Pediatric ICU								
9.	Other			*******					******
10.	Other								
	Other								
12.	Other								
13.	Other						000000000000000000000000000000000000000		
	Other								
16.	Other								
17.	Other								
	Other								
19.	Other								800000000000000000000000000000000000000
20.	Other								
	Newborn Nursery	5	1,825		648	35.51%			
22.	Total	61	22,265	*********	11,321	50.85%	000000000000000000000000000000000000000	1,763	6.05
23.	Observation Bed Days	58888888888	22,200		11,021	38333333333	30000000000	5333333333	
	Obodivation Bod Bayo	<u> </u>	<u> </u>	************				B0000000000000000000000000000000000000	<u> </u>
	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	Adults and Pediatrics		***************************************	(0)	9		(0)	64	29.81
	Psych				, ,			<u> </u>	20.01
	Rehab	200000000	**********			***********			
	Other (Sub)	 	*******						
	Intensive Care Unit	 	***************************************			**********	**********	**********	
	Coronary Care Unit								
	NeoNatal ICU				1,899				
	Pediatric ICU				.,555				
9.	Other								
10.	Other	********							
11.	Other								
12.	Other								
13.	Other								
	Other								
	Other								
17.	Other								
	Other								
	Other								
	Newborn Nursery				194				
	Total	(XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		*****	2,102	18.57%	******	64	29.81
22.	110001	<u> </u>	<u> </u>		۷,۱۷۷	10.01 /0		I 04	29.01

Line			
No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

1 i ciiiiiiiai j			
Medicare Provider Number:		Medicaid Provider Number:	
	18009		
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2022 To: 06/30/20)23

					T . (.)	T . (.)		0/5
					Total	Total	I/P	O/P
		Total Dept.	Total Dept.		Billed I/P	Billed O/P	Expenses	Expenses
		Costs	Charges		Charges	Charges	Applicable	Applicable
		(CMS 2552-10	(CMS 2552-10	Ratio of	(Gross) for	(Gross) for	to Health	to Health
		W/S C,	W/S C,	Cost to	Health Care	Health Care	Care	Care
Line		Pt. 1,	Pt. 1,	Charges	Program	Program	Program	Program
No.	Ancillary Service Cost Centers	Col. 1)	Col. 8)*	(Col. 1 / 2)	Patients	Patients	(Col. 3 X 4)	(Col. 3 X 5)
	-	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	19,035,673	64,435,028	0.295424	143,401	(-)	42,364	(/
	Recovery Room	1,617,718	6,265,306	0.258203	384		99	
	Delivery and Labor Room	5,728,188	18,062,872	0.317125				
	Anesthesiology	1,251,569	13,916,868	0.089932	26,856		2,415	
	Radiology - Diagnostic			0.009932			52,062	
		11,092,512	81,316,200		381,656		52,062	
	Radiology - Therapeutic	3,162,748	16,246,488	0.194673				
	Nuclear Medicine	1,728,445	15,556,483	0.111108				
	Laboratory	14,433,739	128,113,731	0.112663	718,127		80,906	
	Blood	1						
	Blood - Administration	18,107						
	Intravenous Therapy	646,127	14,625,554	0.044178				
12.	Respiratory Therapy	4,081,306	25,530,540	0.159860	2,713,083		433,713	
13.	Physical Therapy	2,954,979	15,882,245	0.186055	239,732		44,603	
14.	Occupational Therapy							
	Speech Pathology							
16.	EKG	2,710,395	38,967,321	0.069556	261,263		18,172	
17.	EEG	1,357,510	9,232,567	0.147035	85,429		12,561	
	Med. / Surg. Supplies	22,788,301	101,712,160	0.224047	1.326.531		297,205	
	Drugs Charged to Patients	28,397,846	150,473,291	0.188723	1,093,014		206,277	
	Renal Dialysis	830,431	1,393,435	0.595960	1,000,014		200,211	
-	Ambulance	1,100,222	1,090,400	0.090900				
	Implants	11,222,175	66,783,542	0.168038	8,055		1,354	
-	· · · · · · · · · · · · · · · · · · ·				6,055		1,354	
	GI Lab	3,428,689	13,905,359	0.246573	40.050		0.050	
	MRI	1,904,540	24,629,736	0.077327	43,352		3,352	
	CT Scan	3,278,550	90,974,188	0.036038	19,051		687	
	Cardiac Cath							
	Special Surgical Serv	542,804	3,124,517	0.173724				
	Genetic Services	418,437	160,232	2.611445				
29.	Pain Center	1,301,602	12,959,405	0.100437				
30.	Antenatal Test Center	1,388,645	10,059,965	0.138037				
31.	Child Psychiatric Clinic	61,888	167,148	0.370259				
32.	Injectable Drugs							
33.	Other Clinics	9,132,722	35,963,957	0.253941				
34.	Other							
35.	Other	1						
	Other	1						
	Other	1						
	Other	1						
	Other	†						
	Other	†						
	Other	+						
	Other	1						
42.] ************************************	 	l ************		 	300000000000000000000000000000000000000
40	Outpatient Service Cost Centers	<u> </u>			<u> </u>			
	Clinic	11.000.005	40.740.00:	0.01010=			4.00:	
	Emergency	11,992,306	48,710,224	0.246197	4,444		1,094	
	Observation	4,790,226	12,306,845	0.389233				
46.	Total	p:::::::::::::::::::::::::::::::::::::			7,064,378		1,196,864	

^{*} If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Medicare Provider Number: Medicaid Provider Number:					
14-0239	18009				
Program:	Period Covered by Statement:				
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023				

Program Inpatient Operating Cost

Line		Adults and	Sub I	Sub II	Sub III
No.	Description	Pediatrics	Psych	Rehab	Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of				
	swing bed and private room cost differential) (see instructions)	62,653			
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	57			
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	1,099.18			
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)	9			
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)	9,893			
4.	Average per diem private room cost differential				
	(BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable				
	to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable				
	to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost				
	(Line 3 + Line 6)	9,893			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	()	(=)	(5)	(=)	(-/
9.	Coronary Care Unit					
	NeoNatal ICU	13,371,364	10,616	1,259.55	1,899	2,391,885
11.	Pediatric ICU	416		·		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	979,584	648	1,511.70	194	293,270
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,196,864
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,891,912

Hospital Statement of Cost Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

Preliminary					
Medicare Provider Number:	Medicaid Provider Number:				
14-0239	18009				
Program:	Period Covered by Statement:				
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023				

Line No.	Hospital Inpatient Services	Percent of Assign- able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 5) (6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics						
	(General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NeoNatal ICU						
9.	Pediatric ICU						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

				Total					
				Dept.					
		Percent	Expense	Charges					
	Hospital	of Assign-	Alloca-	(CMS					
	Outpatient	able Time	tion	2552-10,	Ratio of	Program	Charges		
	Services	(CMS	(CMS	W/S C,	Cost to	(BHF F	Page 3,	Program	Expenses
		2552-10,	2552-10,	Pt.1,	Charges	Cols. 4-5, L	ines 43-45)	(Col. 4 X C	Cols. 5A-B)
Line		W/S D-2,	W/S D-2,	Lines	(Col. 2 /				
No.		Col. 1)	Col. 2)	88-93)	Col. 3)	Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs.								
	(Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)							_	

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

1 i ciiiiiiiii j					
Medicare Provider Number:		Medicaid I	Provider Number:		
	14-0239			18009	
Program:		Period Co	vered by Statement:		
Medicaid Hospital		From:	07/01/2022	To:	06/30/2023

Professional Charges Professional Charges Program			1	Total Dans	Detie of		0	l	0.444
Component Component Component Charges Charges Expenses For Harp				Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
Cost Centers						_		_	_
Line No. Cost Centers (WS A-8-2, Pt. 1, Col. 17 Page 3, Page 3, Col. 3X (Col. 3X Col. 5) Col. 4) Col. 5 Col. 5 Col. 5 Col. 4) Col. 5 C						_	_	•	
No. Inpatient Ancillary Cost Centers (1) (2) (3) (4) (5) (6) (7)			•	-		•	•		
Inpatient Ancillary Cost Centers		Cost Centers	,		-			•	•
1. Operating Room			Col. 4)	Col. 8)*	Col. 2)		Col. 5)	Col. 4)	Col. 5)
2. Recovery Room 3. Delivery and Labor Room 4. Anesthesiology 5. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 23. Gl Lab 24. MRI 25. GT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 9. Pain Center 10. Antenatal Test Center 10. Child Psychiatric Clinic 10. Children 10. Other			(1)	(2)	(3)	(4)	(5)	(6)	(7)
3. Delivery and Labor Room 4. Anesthesiology 5. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 19. Respiratory Therapy 10. Respiratory Therapy 11. Ambulance 12. Implants 13. Anolulance 14. Amiliance 15. GT Scan 16. Cardiac Cath 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 10. Renal Dialysis 10. Anolulance 11. Ambulance 12. Implanta 10. Anolulance 13. Gt Lab 14. Anolulance 15. GT Scan 16. Cardiac Cath 17. Special Surgical Serv 18. Genetic Services 19. Pain Centerr 19. Special Surgical Serv 19. Genetic Services 19. Pain Centerr 19. Drugs Charged to Here 19. D									
4. Anesthesiology 5. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 23. Gl Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Speedia Surgical Serv 28. Genetic Services 29. Paid Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 33. Antenatal Test Center 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other 42. Other 43. Clinic 44. Emergency 45. Other 46. Other 47. Other 48. Circlinic 49. Other 40. Other 41. Other 44. Other 45. Other 46. Other 47. Other 48. Circlinic 49. Other 40. Other									
5. Radiology - Diagnostic		,							
6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med / Surg. Supplies 19. Drugs Changed to Patients 20. Renal Dialysis 21. Ambulance 21. Implants 23. Gl Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychatric Clinic 32. Injectable Drugs 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 41. Other 41. Other 41. Other 42. Other 42. Other 43. Clinic 44. Emergency 45. Other 46. Other 47. Other 47. Other 48. Other 49. Other 49. Other 49. Other 40. Other									
7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 24. AMRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Cinics 34. Other 35. Other 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Uniter 43. Clinic 44. Emergency 45. Clinic 46. Clinic 47. Contain Cather 47. Contain Cather 48. Other 49. Other									
8 Laboratory 9 Blood 10 Blood -Administration 11 Intravenous Therapy 12 Respiratory Therapy 13 Physical Therapy 14 Occupational Therapy 15 Speech Pathology 16 EKG 17 EEG 18 Med / Surg. Supplies 19 Drugs Charged to Patients 19 Drugs Charged to Patients 20 Renal Dialysis 21 Ambulance 22 Implants 23 Gi Lab 44 MRI 25 CT Scan 26 Cardiac Cath 27 Special Surgical Serv 28 Genetic Services 39 Pain Center 30 Antenat Test Center 31 Child Psychiatric Clinic 32 Impleads 33 Other 34 Other 35 Other 36 Other 37 Other 38 Other 39 Other 30 Other 31 Child Psychiatry Cost Centers 41 Clinic 44 Emergency 45 Observation									
Blood Blood - Administration									
10 Blood - Administration	8.	Laboratory							
11. Intravenous Therapy	9.	Blood							
12. Respiratory Therapy									
13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renab Dialysis 21. Ambulance 22. Implants 23. GI Lab 24. MRI 25. GT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 31. Child Psychiatric Clinic 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 40. Other 41. Other 41. Other 42. Other 44. Emergency 45. Gloservation									
14 Occupational Therapy									
15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 23. GI Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other 34. Other 35. Other 36. Other 37. Other 40. Other 41. Other 41. Other 42. Other 44. Emergency 45. Observation									
16. EKG	14.	Occupational Therapy							
17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 23. GI Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 39. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 31. Child Psychiatric Clinic 31. Child Psychiatric Clinic 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other 44. Cilnic 45. Observation 45. Closervation 46. Closervation	15.	Speech Pathology							
18. Med. / Surg. Supplies									
19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implants 23. Gil Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 40. Other 41. Other 41. Other 42. Other 44. Cilnic 44. Emergency 45. Observation	17.	EEG							
20. Renal Dialysis 21. Ambulance 21. Implants	18.	Med. / Surg. Supplies							
21. Ambulance 22. Implants 23. Gl Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation	19.	Drugs Charged to Patients							
22. Implants 23. GI Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation	20.	Renal Dialysis							
23. GI Lab 24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 44. Emergency 45. Observation	21.	Ambulance							
24. MRI 25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation	22.	Implants							
25. CT Scan 26. Cardiac Cath 27. Special Surgical Serv 28. Genetic Services 29. Pain Center 30. Antenatal Test Center 31. Child Psychiatric Clinic 32. Injectable Drugs 33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	23.	GI Lab							
26. Cardiac Cath	24.	MRI							
27. Special Surgical Serv	25.	CT Scan							
28. Genetic Services 9. Pain Center 30. Antenatal Test Center 9. Antenatal Test Center 31. Child Psychiatric Clinic 9. Company 32. Injectable Drugs 9. Company 33. Other Clinics 9. Company 34. Other 9. Company 35. Other 9. Company 36. Other 9. Company 38. Other 9. Company 40. Other 9. Company 41. Other 9. Company 42. Other 9. Company 43. Clinic 44. Emergency 44. Emergency 9. Observation	26.	Cardiac Cath							
29. Pain Center	27.	Special Surgical Serv							
30. Antenatal Test Center	28.	Genetic Services							
31. Child Psychiatric Clinic	29.	Pain Center							
32. Injectable Drugs	30.	Antenatal Test Center							
33. Other Clinics 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic Emergency 44. Emergency Observation									
34. Other	32.	Injectable Drugs							
35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	33.	Other Clinics							
36. Other	34.	Other							
37. Other	35.	Other							
38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	36.	Other							
39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	38.	Other							
41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation 45. Observation	39.	Other							
42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	40.	Other							
Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
43. Clinic 44. Emergency 45. Observation	42.								
44. Emergency 45. Observation		Outpatient Ancillary Cost Centers							
45. Observation	43.	Clinic							
	44.	Emergency							
46. Ancillary Total	45.	Observation							
	46.	Ancillary Total							

^{*} If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(b)

Preliminary

1 i ciiiiiiiii j					
Medicare Provider Number:		Medicaid I	Provider Number:		
	14-0239			18009	
Program:		Period Co	vered by Statement:		
Medicaid Hospital		From:	07/01/2022	To:	06/30/2023

			Total Days	Professional	Program	Outpatient	Inpatient	Outpatient
		Professional	Including	Component	Days	Program	Program	Program
		Component	Private	Cost	Including	Charges	Expenses	Expenses
		(CMS 2552-10	(CMS 2552-10	Per Diem	Private	(BHF	for H B P	for H B P
Line	Cost Centers	W/S A-8-2,	W/S S-3	(Col. 1 /	(BHF Pg. 2	Page 3,	(Col. 3 X	(Col. 3 X
No.		Col. 4)	Pt. 1, Col. 8)	Col. 2)	Pt. II, Col. 4)	Col. 5)	Col. 4)	Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NeoNatal ICU							
54.	Pediatric ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
	Routine Total (lines 47-66)							
	Ancillary Total (from line 46)	1						
69.	Total (Lines 67-68)							

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Computation of Lesser of Reasonable Cost or Customary Charges

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Medicare Provider Number:		Medicaid Provider Number:			
	14-0239	18009			
Program:		Period Co	overed by Statement:		
	Medicaid Hospital	From:	07/01/2022	To:	06/30/2023

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services		
	(BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services		
	(BHF Page 4, Line 25)	3,891,912	
3.	Interns and Residents Not in an Approved Teaching		
	Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services		
	(BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians		
	(BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education		
	(BHF Supplement No. 2, Cols. 6 and 7, Line 69)	31,486	
7.	Total Reasonable Cost of Covered Services		
	(Sum of Lines 1 through 6)	3,923,398	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost		
	(Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

		Program	Program
Line	Customary Charges	Inpatient	Outpatient
No.	, , ,	(1)	(2)
9.	Ancillary Services		
	(See Instructions)	7,064,378	
10.	Inpatient Routine Services		
	(Provider's Records)		
	A. Adults and Pediatrics	18,084	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NeoNatal ICU	15,071,783	
	H. Pediatric ICU		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,302,784	
11.	Services of Teaching Physicians		
	(Provider's Records)		
12.	Total Charges for Patient Services		
	(Sum of Lines 9 through 11)	23,457,029	
13.	Excess of Customary Charges Over Reasonable Cost		
	(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		19,533,631
14.	Excess of Reasonable Cost Over Customary Charges		
	(Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient		
	(Line 8, Each Column X Line 14)		

Medicare Provider Number:	Medicaid Provider Number:					
14-0239	1	18009				
Program:	Period Covered by Statement:					
Medicaid Hospital	From: 07/01/2022	To:	06/30/2023			

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1	Total Reasonable Cost of Covered Services	(1)	(2)
	(BHF Page 7, Line 7, Cols. 1 & 2)	3,923,398	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	3,923,398	
4.	Recovery of Excess Reasonable Cost Under		
	Lower of Cost or Charges		
	(BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items)		
	In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost		
	(Sum of Lines 3 and 4, Plus or Minus Line 5)	3,923,398	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable		
	(Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) *		
	(Line 6 Minus Line 8)		

 $^{^{\}star}$ Line 9 DOES NOT APPLY to the Medicaid program.

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Medicare Provider Number:	Medicaid Pro	vider Number:				
	14-0239			18009		
Program:		Period Cove	ed by Statement:			
Medicaid Hospital		From:	07/01/2022		To:	06/30/2023

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed			
No.	Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)			
1.	Excess of Customary Charges Over Reasonable Cost			
	(BHF Page 7, Line 13) 19,533,631			
2.	Carry Over of Excess Reasonable Cost			
	(Must Equal Part II, Line 1, Col. 5)			
3.	Recovery of Excess Reasonable Cost			
	(Lesser of Line 1 or 2)			

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

					Current	
Prior Cost Reporting Period Ended				Ended	Cost	Sum of
Line	Description	to	to	to	Reporting	Columns
No.					Period	1 - 4
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over -					
	Beginning of					
	Current Period					
2.	Recovery of Excess					
	Reasonable Cost					
	(Part I, Line 3)					
3.	Excess Reasonable					
	Cost - Current					
	Period (BHF Page 7,					
	Line 14)					
4.	Carry Over - End of		_			
	Current Period					
	(Line 1 Minus Line 2					
	or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

			Inpatient		Outpatient	
Line	Description	Cols. 1-3,		Amount		Amount
No.		Line 2)	Ratio	(Col. 1x2A)	Ratio	(Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period					
	ended					
2.	Cost Report Period					
	ended					
3.	Cost Report Period					
	ended					
4.	Total					
	(Sum of Lines 1 - 3)					

Teaching Physicians / Routine Services Questionnaire

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Medicare Provider Number:		Medicaid Provider Number:				
14-0239			18009			
Program:	Period Covere	ed by Statement:				
Medicaid Hospital	From:	07/01/2022	To:	06/30/2023		

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem	·
	(CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem	
	(CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem	
l	(Line 1 Plus Line 2)	

Part B. Program Data	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
Program inpatient days (BHF Page 2, Part II, Column 4)				
Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6.	Program inpatient cost (Line 4 X Line 3)				
	(to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3)				
İ	(to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and	Subi	Sub II	Sub III
		Pediatrics	Psych	Rehab	Other (Sub)
	(A) General inpatient routine service charges (Excluding swing				
	bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding				
	swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges				
	(A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days				
	(CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days				
	(CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem				
	(1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem				
	(1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem				
	(Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4)				
	((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27)				
	Divided by (Line 1A Above))				
7.	Private room cost differential adjustment				
	(Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and				
	private room cost differential)				
	(CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	Adjusted general inpatient routine service cost per diem (Line 8				
	Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

11 Chiminal y	
Medicare Provider Number:	Medicaid Provider Number:
14-0239	18009
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

		1	Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
		GME	Charges	GME	Program	Program	Program	Program
		Cost	(CMS 2552-10	_	Charges	Charges	Expenses	Expenses
		(CMS 2552-10	1	to Charges	(BHF	(BHF	for G M E	for G M E
Line	Cost Centers	W/S B, Pt. 1,	Pt. 1,	(Col. 1 /	Page 3,	Page 3,	(Col. 3 X	(Col. 3 X
No.	555. 556.5	Col. 25)	Col. 8)*	Col. 2)	Col. 4)	Col. 5)	Col. 4)	Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	Operating Room	164,548	64,435,028	0.002554	143,401	(0)	366	(-,
	Recovery Room		,,					
	Delivery and Labor Room	483,102	18,062,872	0.026746				
	Anesthesiology	100,102	10,002,012	0.0201.10				
	Radiology - Diagnostic	476.075	81,316,200	0.005855	381.656		2,235	
	Radiology - Therapeutic	169,818	16,246,488	0.010453	00.,000		2,200	
	Nuclear Medicine	100,010	10,210,100	0.010100				
	Laboratory							
	Blood							
	Blood - Administration							
	Intravenous Therapy							
	Respiratory Therapy							
	Physical Therapy	325,582	15,882,245	0.020500	239,732		4,915	
	Occupational Therapy	020,002	10,002,210	0.020000	200,702		1,010	
	Speech Pathology							
	EKG	725,532	38,967,321	0.018619	261,263		4,864	
	EEG	741.343	9,232,567	0.080297	85,429		6,860	
	Med. / Surg. Supplies	741,040	3,202,001	0.000237	00,425		0,000	
	Drugs Charged to Patients							
	Renal Dialysis							
	Ambulance							
	Implants							
	GI Lab	493,057	13,905,359	0.035458				
	MRI	430,007	10,300,003	0.000-000				
	CT Scan							
	Cardiac Cath							
	Special Surgical Serv	254,726	3,124,517	0.081525				
	Genetic Services	40,990	160,232	0.255817				
	Pain Center	10,000	100,202	0.200011				
	Antenatal Test Center							
	Child Psychiatric Clinic							
	Injectable Drugs							
		268,195	35,963,957	0.007457				
		200,190	00,000,001	0.001 401				
		1						
36.	Other							
	Other							
	Other	1						
	Other	1						
	Other							
	Other	1						
	Other	1						
₹2.	Outpatient Ancillary Centers	<u> </u>			30333333333			
43	Clinic	***********		******************************		~~~~~~~~~	************	·····
	Emergency	688,640	48,710,224	0.014137	4,444		63	
	Observation	300,0 10	.5,. 10,224	5.511107	1, 1 1 4		55	
	Ancillary Total		************	000000000000000000000000000000000000000	***********	000000000000000000000000000000000000000	19,303	

^{*} If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

11 Chiminai y	
Medicare Provider Number:	Medicaid Provider Number:
14-0239	18009
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

		GME	Total Days Including	GME	Program Days	Outpatient Program	Inpatient Program	Outpatient Program
		Cost	Private	Cost	Including	Charges	Expenses	Expenses
		(CMS 2552-10	(CMS 2552-10	Per Diem	Private	(BHF	for G M E	for G M E
Line	Cost Centers	W/S B, Pt. 1,	W/S S-3, Pt. 1,	(Col. 1 /	(BHF Pg. 2	Page 3,	(Col. 3 X	(Col. 3 X
No.		Col. 25)	Col. 8)	Col. 2)	Pt. II, Col. 4)	Col. 5)	Col. 4)	Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	14,134	57	247.96	9		2,232	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NeoNatal ICU	55,630	10,616	5.24	1,899		9,951	
54.	Pediatric ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery			_			_	
67.	Routine Total (lines 47-66)						12,183	
68.	Ancillary Total (from line 46)	100000000000000000000000000000000000000					19,303	
69.	Total (Lines 67-68)	100000000000000000000000000000000000000					31,486	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

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Pre	liı	mi	ns	r

	1 Community					
Medicare Provider Number:		Medicaid Provider Number:				
14-0239		18009				
	Program:	Period Covered by Statement:				
	Medicaid Hospital	From: 07/01/2022 To: 06/30/2023				

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,908		1,908
Newborn Days	194		194
Total Inpatient Revenue	23,470,601	(13,572)	23,457,029
Ancillary Revenue	7,064,378		7,064,378
Routine Revenue	16,406,223	(13,572)	16,392,651
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			
Notes:			
Preliminary Audit Adjustments:			
BHF Page 2 - Adjusted the Beds and Bed Days Available to a	gree with the revised cost reported	I amounts submitted by	
the provider 1/31/24 BHF Page 2 - Adjusted the Part I-Hospital I/P Days to agree w	vith W/S S-3 of the Medicare repor	t	
BHF Page 2 - Part I - Hospital Discharges allocated between a see attached spreadsheet	Adults & Childrens based upon Inp	atient Days;	
BHF Page 4 and Supplemental 2b - Allocated A&P & Nursery	Routine costs and GME costs bet	ween Acute and Childrens	
based upon attached worksheet. BHF Page 4 - Removed the costs associated with ICU as these	so bolong on the Adult's cost repor	t	
BHF Page 7 - Adjusted out the ICU Routine charges as these			
BHF Supplemental 2a & 2b - Added per W/S B, part I, col 25 o	of the Medicare report		
	or the Medicare report		
	or the Medicare report		
	от ше месисате теротт		
	от те мецісате тероті		
	or the Medicare report		
	от те мецісате тероті		
	от те мецісате терот		
	or the Medicare report		
	or the Medicare report		
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	or the Medicare report		