General Information	Preliminary			
Name of Hospital:		Medicare Provider Number:		
Louis Weiss Memorial Hos	spital	14-0082		
Street: 4646 North Marine Drive		Medicaid Provider Number: 3067		
City:	State:	Zip:		
Chicago	Illinois	60640		
Period Covered by Statement:	From:	To:		
Type of Control	06/01/2023	12/31/2023		
Voluntary Nonprofit	Proprietary	Government (Non-Federal)		
Church	Individual	State Township		
Corporation	Partnership	City Hospital District		
Other (Specify)	XXXX Corporation	County Other (Specify)		
Type of Hospital				
XXXX General Short-Term	Psychiatric	Cancer		
General Long-Term	Rehabilitation	Other (Specify)		
Health Care Program	(A Separate Report Must B	Be Filled Out For Each Distinct Part Unit)		
Medicaid Hospital	XXXX Medicaid Sub II Rehab			
Medicaid Sub I Psych	Medicaid Sub III Other			
NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law  CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):				
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s))  Louis Weiss Memorial Hospita 3067  for the cost report beginning  06/01/2023 and ending  12/31/2023 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.				
Prepared by (Signed):		Signed (Officer or Administrator of Provider(s)):		
Name (Typewritten)		Name (Typewritten)		
Title	Date	Title		
Firm		Date		
Telephone Number		Telephone Number		
Email Address		Email 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.

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Tremmary	
Medicare Provider Number:	Medicaid Provider Number:
14-0082	3067
Program:	Period Covered by Statement:
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023

					Total	Percent		Number Of	Average
•					Inpatient	Of	Number	Discharges	Length Of
			T-4-1	T-4-1	•	_		_	_
			Total	Total	Days	Occupancy	Of	Including	Stay By
	Inpatient Statistics	Total	Bed	Private	Including	(Column 4	Admissions	Deaths	Program
Line		Beds	Days	Room	Private	Divided By	Excluding	Excluding	Excluding
No.		Available	Available	Days	Room Days	Column 2)	Newborn	Newborn	Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Adults and Pediatrics	103	22,042		8,810	39.97%		3,804	2.84
	Psych	11	2,354		1,448	61.51%		185	7.83
	Rehab	14	2,996		1,064	35.51%		165	6.45
	Other (Sub)								
	Intensive Care Unit	16	3,424		1,978	57.77%			
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
	Other								
	Other	1							
	Other								
	Other								
	Other								
	Other								
	Other								
	Other								
	Other								
	Other								
	Newborn Nursery								
		444	00.040		40.000	40.400/		4.454	0.00
	Total	144	30,816		13,300	43.16%		4,154	3.20
23.	Observation Bed Days				976				
	D 111 D	(4)	(2)	(0)	(4)		(0)		
	Part II-Program	(1)	(2)					(=\)	
1.	Adults and Pediatrics		(-)	(3)	(4)	(5)	(6)	(7)	(8)
2.	radice dira r ediatires		(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Psych		(=)	(3)		(5)	(6)		
3.	Psych Rehab		(=)	(3)	130	(5)	(6)	(7)	(8)
3. 4.	Psych Rehab Other (Sub)		(=)	(3)		(5)	(6)		
3. 4. 5.	Psych Rehab Other (Sub) Intensive Care Unit		(=)	(3)		(5)	(6)		
3. 4. 5. 6.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit		(=)	(3)		(5)	(6)		
3. 4. 5. 6.	Psych Rehab Other (Sub) Intensive Care Unit		(-)	(3)		(5)	(6)		
3. 4. 5. 6. 7.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit		12	(3)		(5)	(6)		
3. 4. 5. 6. 7.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other		(-)	(3)		(5)	(6)		
3. 4. 5. 6. 7. 8.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other		12-)	(3)		(5)	(6)		
3. 4. 5. 6. 7. 8. 9.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other		(=)	(3)		(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other Other Other Other Other Other		(=)	(3)		(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other Other Other Other Other Other Other Other		(-)	(3)		(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other		(=)			(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 16.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 16.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 16. 17.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 16. 17. 18. 19.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					(5)	(6)		
3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 16. 17. 18. 19.	Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other					0.98%	(6)		

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

### Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

BHF Page 3

Preliminar

i i Cilillinai y			
Medicare Provider Number:		Medicaid Provider Number:	
	14-0082	3067	
Program:		Period Covered by Statement:	
Medicald Hospital		From: 06/01/2023 To: 12/31/203	23

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
	Operating Room	1,350,481	18,631,186	0.072485	598		43	
	Recovery Room	563,463	3,777,686	0.149156	99		15	
	Delivery and Labor Room							
	Anesthesiology	2,185,019	4,460,820	0.489825	84		41	
	Radiology - Diagnostic	3,434,474	7,103,647	0.483480	3,672		1,775	
6.	Radiology - Therapeutic	451,261	583,919	0.772814				
7.	Nuclear Medicine	259,027	1,438,343	0.180087	842		152	
8.	Laboratory	1,410,091	42,108,127	0.033487	55,110		1,845	
9.	Blood							
10.	Blood - Administration	366,647	1,662,111	0.220591	482		106	
	Intravenous Therapy							
	Respiratory Therapy	1,122,752	3,898,609	0.287988	4,571		1,316	
	Physical Therapy	1,492,847	8,538,430	0.174839	176,801		30,912	
	Occupational Therapy	1,10=,011	2,000,000		,		00,01=	
	Speech Pathology							
	EKG	965,206	5,889,209	0.163894	3,386		555	
	EEG	35,354	112,698	0.313706	0,000		000	
	Med. / Surg. Supplies	7,047,726	23,845,369	0.295560	105		31	
	Drugs Charged to Patients	6,594,371	37,687,396	0.174976	28,242		4,942	
	Renal Dialysis	372,159	488,337	0.762095	20,242		7,572	
	Ambulance	372,133	400,007	0.702033				
	Vascular Lab	203,642	1,424,145	0.142992				
	Implant Supplies	4,960,767	10,395,967	0.477182				
	Wound Care	361,183	745,538	0.484460				
	GI Lab	96,218	3,594,022	0.464400				
			, ,		7 404		205	
	CT Scan	767,354	26,836,807	0.028593	7,181		205	
	MRI	235,031	3,565,835	0.065912	1,048		69	
	Strauss Oncology	445,497	1,343,811	0.331518	0.17		00	
	Ultrasound	170,947	1,662,324	0.102836	217		22	
	Psych Clinic	257,055	155,665	1.651335				
	Cath Lab	472,110	7,216,438	0.065421				
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
40.	Other							
	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	1,081,887	1,700,119	0.636360				
44.	Emergency	3,574,096	28,751,857	0.124308				
	Observation	1,102,285	2,041,440	0.539955				
	Total	, , , , ,	, , , , , ,		282,438		42,029	

<sup>\*</sup> 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.

### Hospital Statement of Cost / Computation of Inpatient Operating Cost

BHF Page 4

Preli	i	^**

Medicare Provider Number:	Medicaid Provider Number:	
14-0082	3067	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023	

### **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)	11,052,212	2,627,110	1,848,950	
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	9,786	1,448	1,064	
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	1,129.39	1,814.30	1,737.73	
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)			130	
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)			225,905	
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)			225,905	

		Total Dept. Costs	Total Days (CMS 2552-10,	Average	Program Days	
Line		(CMS 2552-10,	W/S S-3,	Per Diem	(BHF Page 2,	Program Cost
No.	Description	W/S C, Pt. 1, Col. 1)	Part 1, Col. 8)	(Col. A / Col. B)	Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	3,383,238	1,978	1,710.43		
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
	Nursery					
24.	Program inpatient ancillary care service cost					
	(BHF Page 3, Col. 6, Line 46)					42,029
25.	Total Program Inpatient Operating Costs					·
	(Sum of Lines 7 through 24)					267,934

## 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:
14-0082	3067
Program:	Period Covered by Statement:
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023

Line No.	Hospital Inpatient Services	Percent of Assign- able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca- tion (CMS 2552-10, W/S D-2, Col. 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.	Other						
9.	Other						
10.	Other						
11.	Other						
	Other						
13.	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign- able Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Alloca- tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3)	(BHF I	Charges Page 3, ines 43-45) Outpatient (5B)	•	Expenses Cols. 5A-B) Outpatient (6B)
	OI: :	(1)	(2)	(3)	(+)	(3A)	(36)	(UA)	(00)
	Clinic								
24.	Emergency								
25.	Observation							•	
	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)

Preliminary	
Medicare Provider Number:	Medicaid Provider Number:
14-0082	3067
Program:	Period Covered by Statement:
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023

		Professional Component	Total Dept. Charges (CMS 2552-10,	Ratio of Professional Component	Inpatient Program Charges	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
		(CMS 2552-10,	W/S C,	to Charges	(BHF	(BHF	for H B P	for H B P
Line	Cost Centers	W/S A-8-2,	Pt. 1,	(Col. 1 /	Page 3,	Page 3,	(Col. 3 X	(Col. 3 X
No.		Col. 4)	Col. 8)*	Col. 2)	Col. 4)	Col. 5)	Col. 4)	Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
	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							
	Speech Pathology							
	EKG							
	EEG							
	Med. / Surg. Supplies							
	Drugs Charged to Patients							
	Renal Dialysis							
	Ambulance							
	Vascular Lab							
	Implant Supplies							
	Wound Care							
	GI Lab							
	CT Scan							
	MRI							
	Strauss Oncology							
	Ultrasound							
	Psych Clinic							
	Cath Lab							
	Other							
	Other Other							
	Other							
	Other							
	Other	1	-	-	1	-	1	
	Other							
	Other							
	Other							
	Other							
	Other							
	Outpatient Ancillary Cost Centers							
43	Clinic							
	Emergency	İ						
	Observation	İ						
	Ancillary Total							
							l .	

<sup>\*</sup> 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			
Medicare Provider Number:	Medicaid Provider Number:		
14-0082		3067	
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 06/01/2023	To:	12/31/2023

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Adults and Pediatrics							
	Psych							
	Rehab							
	Other (Sub)							
	Intensive Care Unit							
	Coronary Care Unit							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other			, in the second second				
	Other							
	Nursery							
	Routine Total (lines 47-66)							
	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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Medicare Provider Number:		Medicaid Provider Number:			
14-0082			3067		
Program:		Period Covered by Statement:	_		
	Medicaid Hospital	From: 06/01/2023	To: 12/31/2023		
Line		Program	Program		
No.	Reasonable Cost	Inpatient	Outpatient		
		(1)	(2)		
1.	Ancillary Services				
	(BHF Page 3, Line 46, Col. 7)				
2.	Inpatient Operating Services				
	(BHF Page 4, Line 25)	267,934			
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)	48			
7.	Total Reasonable Cost of Covered Services				
	(Sum of Lines 1 through 6)	267,982			
8.	Ratio of Inpatient and Outpatient Cost to Total Cost				
	(Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%			

Line	Customary Charges	Program Inpatient	Program Outpatient
No.		(1)	(2)
9.	Ancillary Services		
	(See Instructions)	282,438	
10.	Inpatient Routine Services		
	(Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	302,200	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11	Services of Teaching Physicians		
	(Provider's Records)		
12.	Total Charges for Patient Services		
	(Sum of Lines 9 through 11)	584,638	
13	Excess of Customary Charges Over Reasonable Cost	55 1,555	
	(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		316,656
14	Excess of Reasonable Cost Over Customary Charges		210,000
l '''	(Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15	Excess Reasonable Cost Applicable to Inpatient and Outpatient		
'0.	(Line 8, Each Column X Line 14)		
	KEINO O, EGON COMMINITY LINE 14)		

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Medicare Provider Number:	Medicaid Provider Number:
14-0082	3067
Program:	Period Covered by Statement:
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services		
	(BHF Page 7, Line 7, Cols. 1 & 2)	267,982	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	267,982	
4.	Recovery of Excess Reasonable Cost Under		
	Lower of Cost or Charges		
	(BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
	Protested Amounts (Nonallowable Cost Items)		
	In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
	Total Allowable Cost		
	(Sum of Lines 3 and 4, Plus or Minus Line 5)	267,982	

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)		
	Balance Due Provider / (State Agency) *		
	(Line 6 Minus Line 8)		

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

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Preliminary

- 1 cmmm j					
Medicare Provider Number:	icare Provider Number: Medicaid Provider Number:				
14-00	82		3067		
Program:	Period C	overed by Statement:			
Medicaid Hospital	From:	06/01/2023	To:	12/31/2023	

#### 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)	316,656				
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

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

		Total (Part II,	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)					

renminary				
Medicare Provider Number:	Medicaid Provider Number:			
14-0082	3067			
Program:	Period Covered by Statement:			
Modicaid Hospital	From: 06/01/2023 To: 12/31/2023			

#### 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
	(Line 1 Plus Line 2)

		General	Sub I	Sub II	Sub III
	Part B. Program Data	Service	Psych	Rehab	Other (Sub)
4.	Program inpatient days				
	(BHF Page 2, Part II, Column 4)				
5.	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)				
ı	(to BHF Page 7, Col. 2, Line 5)				

#### Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and	Sub I	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)				

Preliminar

1 Tellimar J					
Medicare Provider Number:		Medicaid I	Provider Number:		
	14-0082			3067	
Program:		Period Co	vered by Statement:		
Medicaid Hospital		From:	06/01/2023	To:	12/31/2023

Cost	Inpatient Outpatient	Outpatient	Inpatient	Ratio of	Total Dept.			
Cost   Charges					GMF			
Cost Centers   Cost Centers   WS C, WS B, Pt. 1, Col. 12   Col. 13   Col. 14   Col. 12   Col. 14   Col. 12   Col. 15   Col.		_	_			_		
Line		_	_		•			
No.		,		_		,	Cost Centers	l ine
Inpatient Ancillary Centers   1   2   3   4   5   6   6     1   1   1   2   3   4   5   5   6     2   Recovery Room   1,507,682   18,631,186   0.080922   598   48     2   Recovery Room   3   Delivery and Labor Room   4   Anesthresiology   5   Radiology - Diagnostic   6   Radiology - Diagnostic   7   Nuclear Medicine   Nuclear Medicine   7   Nuclear Medicine   Nuclear Medic	,			•				
1.   Operating Room							Innatient Ancillary Centers	
2. Recovery Room		(0)						
3. Delivery and Labor Room	40	-	000	0.000022	10,001,100	1,007,002		
4 Anesthesiology   5 Radiology - Diagnostic   6 Radiology - Diagnostic   7 Nuclear Medicine   8 Laboratory   9 Blood   9 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   +	-					Delivery and Lahor Room	3	
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           20. Renal Dialysis           21. Ambulance           22. Vascular Lab           23. Implant Supplies           24. Wound Care           25. Gl Lab           26. CT Scan           27. MRI           28. Strauss Oncology           29. Ultrasound           30. Psych Clinic           31. Cath Lab           32. Other           33. Other           34. Other           35. Other           36. Other           37. Other           38. Other           39. Other           40. Other           41. Other           42. Other           43. Clinic	+ + + + + + + + + + + + + + + + + + + +	-						
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. Vascular Lab 23. Implant Supplies 24. Wound Care 25. GI Lab 26. CT Scan 27. MRI 28. Strauss Oncology 29. Ultrasound 30. Psych Clinic 31. Cath Lab 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 40. Other 40. Other 41. Other 42. Other 43. Other	+ + + + + + + + + + + + + + + + + + + +	-						
7. Nuclear Medicine   8. Laboratory   9. Blood   9. Blood   10. Blood - Administration   11. Intravenous Therapy   12. Respiratory 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 Patient	+ + + + + + + + + + + + + + + + + + + +	-						
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 Dalysis 21. Ambulance 22. Vascular Lab 23. Implant Supplies 24. Wound Care 25. GL Lab 26. CT Scan 27. MRI 28. Strauss Oncology 29. Ultrasound 30. Psych Clinic 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 37. Other 38. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other	<del>                                     </del>	-						
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   10   Renal Dialysis   12   Ambulance   12   Ambulance   12   Ambulance   12   Ambulance   13   Implant Supplies   16   EG   EG   EG   EG   EG   EG   EG   E	<del>                                     </del>	+						
10   Blood - Administration	<del>                                     </del>	+					,	
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.   Vascular Lab   23.   Implant Supplies   24.   Wound Care   25.   GI Lab   26.   CT Scan   27.   MRI   28.   Strauss Oncology   29.   Ultrasound   30.   Psych Clinic   31.   Cath Lab   32.   Other   33.   Other   34.   Other   37.   Other   44.   Other   45.   Other   45.   Other   45.   Other   46.   Other   46.   Other   47.   Other   47.   Other   47.   Other   48.   Other   48.   Other   49.   Ot	<del>                                     </del>	+						
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	+ + + + + + + + + + + + + + + + + + + +	-						
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. Vascular Lab 23. Implant Supplies 24. Wound Care 25. GI Lab 26. CT Scan 27. MRI 28. Strauss Oncology 29. Uitrasound 30. Psych Clinic 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 42. Other	+ + + + + + + + + + + + + + + + + + + +	-						
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. Vascular Lab 23. Implant Supplies 24. Wound Care 25. Gol Lab 26. CT Scan 27. MRI 28. Strauss Oncology 29. Ultrasound 30. Psych Clinic 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 39. Other 40. Other 41. Other 41. Other 42. Other	+ + + + + + + + + + + + + + + + + + + +	-						
15.   Speech Pathology	<del>                                     </del>	+						
16. EKG	<del>                                     </del>	+					Speech Pathology	15
17. EEG         18. Med. / Surg. Supplies         19. Drugs Charged to Patients         20. Renal Dialysis         21. Ambulance         22. Vascular Lab         23. Implant Supplies         24. Wound Care         25. GI Lab         26. CT Scan         27. MRI         28. Strauss Oncology         29. Ultrasound         30. Psych Clinic         31. Cath Lab         32. Other         33. Other         34. Other         35. Other         36. Other         37. Other         38. Other         39. Other         40. Other         41. Other         42. Other         43. Clinic	<del>                                     </del>	+					FKG	16.
18. Med. / Surg. Supplies         19. Drugs Charged to Patients           20. Renal Dialysis	+	+					FEG	17
19. Drugs Charged to Patients   20. Renal Dialysis   3.   21. Ambulance   22. Vascular Lab   3.   Implant Supplies   3.   24. Wound Care   3.   25. GI Lab   3.   26. CT Scan   3.   27. MRI   3.   28. Strauss Oncology   30. Psych Clinic   31. Cath Lab   32. Other   33. Other   34. Other   35. Other   36. Other   37. Other   37. Other   38. Other   39.	+ + + + + + + + + + + + + + + + + + + +	-						
20. Renal Dialysis   21. Ambulance   22. Vascular Lab   23. Implant Supplies   24. Wound Care   25. GI Lab   26. CT Scan   27. MRI   28. Strauss Oncology   29. Ultrasound   20. Vascular Lab   26. CT Scan   27. MRI   28. Straus Oncology   29. Ultrasound   20. Vascular Lab   20.	+ + + + + + + + + + + + + + + + + + + +	-						
21. Ambulance   22. Vascular Lab   23. Implant Supplies   24. Wound Care   25. GI Lab   26. CT Scan   27. MRI   28. Strauss Oncology   29. Ultrasound   30. Psych Clinic   31. Cath Lab   32. Other   33. Other   34. Other   35. Other   36. Other   37. Other   38. Other   39. Other   39. Other   39. Other   39. Other   30. Other   31. Other   31. Other   32. Other   33. Other   34. Other   35. Other   36. Other   37. Other   38. Other   39. Other	<del>                                     </del>	+						
22. Vascular Lab   23. Implant Supplies   24. Wound Care   25. GI Lab   26. CT Scan   27. MRI   28. Strauss Oncology   29. Ultrasound   30. Psych Clinic   31. Cath Lab   32. Other   33. Other   35. Other   35. Other   36. Other   37. Other   37. Other   38. Other   39.  <del>                                     </del>	+							
23. Implant Supplies         24. Wound Care         25. GI Lab         26. CT Scan         27. MRI         28. Strauss Oncology         29. Ultrasound         30. Psych Clinic         31. Cath Lab         32. Other         33. Other         34. Other         35. Other         36. Other         37. Other         38. Other         39. Other         40. Other         41. Other         42. Other         Outpatient Ancillary Centers	<del>                                     </del>	+						
24. Wound Care         25. Gl Lab         26. CT Scan         27. MRI         28. Strauss Oncology         29. Ultrasound         30. Psych Clinic         31. Cath Lab         32. Other         33. Other         34. Other         35. Other         36. Other         37. Other         38. Other         39. Other         40. Other         41. Other         42. Other         43. Clinic								
25. GI Lab 26. CT Scan 27. MRI 28. Strauss Oncology 29. Ultrasound 30. Psych Clinic 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 39. Other 39. Other 30. Other 30. Other 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 41. Other 42. Other 43. Clinic	<del>                                     </del>	+						
26. CT Scan       27. MRI         28. Strauss Oncology       29. Ultrasound         30. Psych Clinic       31. Cath Lab         32. Other       32. Other         33. Other       34. Other         35. Other       35. Other         36. Other       37. Other         38. Other       39. Other         40. Other       40. Other         41. Other       42. Other         Outpatient Ancillary Centers       43. Clinic								
27. MRI								
28. Strauss Oncology       9. Ultrasound         30. Psych Clinic       9. Ultrasound         31. Cath Lab       9. Under         32. Other       9. Under         33. Other       9. Under         35. Other       9. Under         36. Other       9. Under         38. Other       9. Under         39. Other       9. Under         40. Other       9. Under         41. Other       9. Under         42. Other       9. Under         43. Clinic       9. Under								
29. Ultrasound       30. Psych Clinic         31. Cath Lab       31. Cath Lab         32. Other       33. Other         34. Other       35. Other         36. Other       36. Other         37. Other       38. Other         39. Other       39. Other         40. Other       40. Other         41. Other       41. Other         42. Other       43. Clinic								
30. Psych Clinic 31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 39. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic								
31. Cath Lab 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic								
32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	<del>                                     </del>						,	
33. Other  34. Other  35. Other  36. Other  37. Other  38. Other  39. Other  40. Other  41. Other  42. Other  Outpatient Ancillary Centers  43. Clinic	<del>                                     </del>							
34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	<del>                                     </del>							
35. Other	<del>                                     </del>							
36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	<del>                                     </del>							
37. Other	<del>                                     </del>							
38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	<del>                                     </del>							
39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	<del>                                     </del>							
40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	1 1	<del>                                     </del>	İ					
41. Other 42. Other Outpatient Ancillary Centers 43. Clinic	1 1	1						
42. Other Outpatient Ancillary Centers 43. Clinic	1	1						
Outpatient Ancillary Centers 43. Clinic	1	1						
43. Clinic								
								43.
44. Emergency	1 1	1						
45. Observation	1							
46. Ancillary Total 48	48							

<sup>\*</sup> 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.

BHF Supplement No. 2(b)

Hospital Statement of Cost / Graduate Medical Education Expense
Preliminary
Medicare Provider Number:
Medicaid Pro Medicaid Provider Number: 14-0082 3067 Period Covered by Statement: From: 06/01/2023 Program: **Medicaid Hospital** To: 12/31/2023

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	4,129,686	9,786	422.00				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
	Other							
55.	Other							
56.	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Nursery							
	Routine Total (lines 47-66)							
	Ancillary Total (from line 46)						48	
69.	Total (Lines 67-68)						48	

### Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary			
Medicare Provider Number:	Medicaid Provider Number:		
14-0082	3067		
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 06/01/2023 To: 12/31/2023		

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report	
Adult Days	130		130	
Newborn Days				
Total Inpatient Revenue	584,639	(1)	584,638	
Ancillary Revenue	282,439	(1)	282,438	
Routine Revenue	302,200		302,200	
Inpatient Received and Receivable				
Outpatient Reconciliation				
Outpatient Occasions of Service				
Total Outpatient Revenue				
Outpatient Received and Receivable				
Preliminary Audit Adjustments:  BHF Page 1 - Changed the Type of Control to Proprietary Corporation which agrees with the Medicare report BHF Page 2 - Added the Observation days in Part I-Hospital which are the prior cost reported days BHF Page 2 - Part II-Hospital & Part II-Program discharges are the prior cost reported discharges BHF Page 2 - Part II-Program days agree with W/S S-3 of the Medicare report BHF Page 3 - Adjusted the Total Costs/Charges to agree with W/S C, Part I, Cols 1 & 8 of the Medicare report BHF Page 3 - Reclassified Blood Costs/Charges to Blood Admin Costs/Charges to be covered by IL Medicaid BHF Page 6a & 6b - Adjusted out the Professional fees as none on the IPCR BHF Supplemental 2a & 2b - GME costs agreed to W/S B Part 1, column 25.  Minor rounding adjustment  Minor rounding adjustment				