General Information	Preliminary		
Name of Hospital:		Medicare Provide	r Number:
Swedish Covenant Hospita	al		14-0114
Street: 5145 North California Aven	ue.	Medicaid Provide	r Number: 3056
City:	State:	Zip:	3332
Chicago	Illinois		60625
Period Covered by Statement:	From: 01/01/2023	То:	12/31/2023
Type of Control		'	
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			
XXXX General Short-Term	Psychiatric		Cancer
General Long-Term	Rehabilitation		Other (Specify)
Health Care Program	(A Separate Report Must Be	Filled Out For Each Distinct	Part Unit)
Medicaid Hospital	XXXX Medicaid Sub II XXXX Rehab		
Medicaid Sub I Psych	Medicaid Sub III Other		
NOTE: Intentional Misrepresentati By Fine And / Or Imprisonr	ion Or Falsification Of Any Information In nent Under Federal Law	This Cost Report May Be Pu	nishable
CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDER(S):		
Sheet and Statement of Revenue ar for the cost report beginning 01	d the above statement and that I have examined Expense prepared by (Provider name(s) a 101/2023 and ending 12/31/2023 and he books and records of the provider in accords.	and number(s)) Swedis that to the best of my knowled	h Covenant Hospital 3056 ge and belief, it is a true, correct and
Prepared by (Signed):		Signed (Officer or Adn	ninistrator 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.

Medicare Provider Number:	Medicaid Provider Number:
14-0114	3056
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

	I	I		1	Total	Percent		Number Of	Average
					Inpatient	Of	Number	Discharges	Length Of
			Total	Total	Days	Occupancy		Including	Stay By
	Inpatient Statistics	Total	Bed	Private	Including		Admissions	_	Program
Line	inpatient Statistics	Beds	Days	Room	Private	Divided By	Excluding	Excluding	Excluding
No.		Available	Available	Days	Room Days		Newborn	Newborn	Newborn
110.	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	Adults and Pediatrics	146	53,290	(0)	35,071	65.81%	(0)	8,450	4.53
	Psych	31	11,315		5,738	50.71%		787	7.29
	Rehab	30	10.950		6,927	63.26%		505	13.72
	Other (Sub)	00	10,550		0,521	00.2070		000	10.72
	Intensive Care Unit	14	5,110		2,412	47.20%	*********	***********	**********
	Coronary Care Unit	1-	0,110		2,412	47.2070			
	Special Care Nursery	12	4,380		789	18.01%			
	Other	'-	1,000		7.00	10.0170			
	Other								
10.	Other								
	Other								
	Other								
13.	Other							300000000000000000000000000000000000000	***********
	Other								
	Other								
17.	Other								
	Other								
	Other			100000000					
20.	Other								
	Newborn Nursery				3,820				
	Total	233	85,045	*****	54,757	64.39%	***********	9,742	5.23
	Observation Bed Days	888888888888888888888888888888888888888	***********		9,650		*****	***********	**********
		**********			2,000	***********			
	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	*****		(-)	. ,		(-7		(-)
	Psych								
	Rehab	000000000000000000000000000000000000000			213			21	10.14
	Other (Sub)				_				-
	Intensive Care Unit					0000000000			
					4				
	Coronary Care Unit	100000000000000000000000000000000000000							
	Coronary Care Unit Special Care Nursery								
	Special Care Nursery								
	Special Care Nursery Other								
	Special Care Nursery								
9. 10.	Special Care Nursery Other Other								
9. 10.	Special Care Nursery Other Other Other								
9. 10. 11.	Special Care Nursery Other Other Other Other Other								
9. 10. 11. 12.	Special Care Nursery Other Other Other Other Other Other Other								
9. 10. 11. 12. 13.	Special Care Nursery Other Other Other Other Other Other Other Other Other								
9. 10. 11. 12. 13. 14.	Special Care Nursery Other Other Other Other Other Other Other								
9. 10. 11. 12. 13. 14. 16.	Special Care Nursery Other								
9. 10. 11. 12. 13. 14. 16. 17.	Special Care Nursery Other								
9. 10. 11. 12. 13. 14. 16. 17. 18.	Special Care Nursery Other								
9. 10. 11. 12. 13. 14. 16. 17. 18.	Special Care Nursery Other								

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

1 terminary					
Medicare Provider Number:	Medicaid Provider Number:				
14-0114	3056				
Program:	Period Covered by Statement:				
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023				

Limo		W/S C,	Total Dept. Charges (CMS 2552-10 W/S C,	Cost to	Total Billed I/P Charges (Gross) for Health Care	Total Billed O/P Charges (Gross) for Health Care	I/P Expenses Applicable to Health Care	O/P Expenses Applicable to Health Care
Line No.	Ancillary Service Cost Centers	Pt. 1, Col. 1)	Pt. 1, Col. 8)*	Charges (Col. 1 / 2)	Program Patients	Program Patients	Program (Col. 3 X 4)	Program (Col. 3 X 5)
110.	Anomary dervice dost denters	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	18,301,386	181,175,742	0.101015	6,536	(5)	660	(- /
	Recovery Room							
3.	Delivery and Labor Room	8,710,760	24,644,051	0.353463				
4.	Anesthesiology	602,497	14,809,273	0.040684	341		14	
5.	Radiology - Diagnostic	10,499,624	60,093,840	0.174720	4,453		778	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	13,863,217	155,210,911	0.089319	64,246		5,738	
	Blood							
10.	Blood - Administration	1,713,359	2,353,493	0.728007	1,672		1,217	
	Intravenous Therapy							
	Respiratory Therapy	4,557,677	14,896,773	0.305951	7,245		2,217	
	Physical Therapy							
	Occupational Therapy							
	Speech Pathology							
	EKG	6,563,631	55,116,780	0.119086	2,880		343	
	EEG							
	Med. / Surg. Supplies	39,012,136	71,298,284	0.547168	2,846		1,557	
	Drugs Charged to Patients	23,534,927	142,055,065	0.165675	78,393		12,988	
-	Renal Dialysis	784,480	2,612,289	0.300304	16,980		5,099	
	Ambulance	0.004.400	40,000,000	0.457700				
	Cancer Treatment Ctr.	2,064,183	13,089,033	0.157703				
	Ultrasound	3,253,790	26,742,060	0.121673				
	Special Procedures CT Scan/MRI	1,597,517	9,683,078	0.164980	10.065		202	
		3,746,541	118,438,229 94,686	0.031633	12,065		382	
	Pathology Rehab Medicine	1,834,084	,	19.370171 0.341797	271 420		02 774	
	Cath Lab	9,657,370 3,840,871	28,254,665 70,644,559	0.054369	271,429		92,774	
	ASC	1,432,464	16,035,495	0.089331				
	Wound Care	2,370,697	8,637,627	0.009331				
	Pain Management	1,304,441	2,464,458	0.529301				
	Diabetes Center	319,158	199.890	1.596668				
	Family Practice Clinic	515,156	100,000	1.000000				
	Implant Devices	1						
	Niles Infusion Center	27,569,432	120,313,065	0.229147				
	340B Pharmacy	10,293,051	48,051,262	0.214210				
	Other	2, 22,23.	.,,					
	Other							
-	Other							
	Other							
	Other							
	Other							
	Outpatient Service Cost Centers							
43.	Clinic	270,158	63	############				
44.	Emergency	13,542,377		0.090450				
45.	Observation	9,746,114	22,583,343	0.431562	1,865		805	
46.	Total				470,951		124,572	

^{*} 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:			
14-0114	3056			
Program:	Period Covered by Statement:			
Medicaid Hospital	From:	01/01/2023	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)	45,166,595	4,810,229	4,683,115	
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	44,721	5,738	6,927	
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	1,009.96	838.31	676.07	
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)			213	
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)			144,003	
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)			144,003	

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	7,016,945	2,412	2,909.18	. ,	. ,
9.	Coronary Care Unit					
10.	Special Care Nursery	813,254	789	1,030.74		
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,252,665	3,820	851.48		
	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					124,572
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					268,575

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

Freiminary	
Medicare Provider Number:	Medicaid Provider Number:
14-0114	3056
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

Line No.	Hospital Inpatient Services	Percent of Assign- able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense 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)	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						
	Coronary Care Unit						
8.	Special Care Nursery						
	Other						
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)							_	

1 Telliminat j					
Medicare Provider Number:		Medicaid	Provider Number:		
	14-0114			3056	
Program:		Period Co	vered by Statement:		
Medicaid Hospital		From:	01/01/2023	To:	12/31/2023

Professional Charges Professional Charges Professional Charges Program Progr			1	T. (.) D (D. (1) . (1	0.1	1	0.1
Component Component Charges Expenses Expenses Expenses Charges Charges Charges Charges Charges For H BP for HBP fo			L	Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
CMS 2552-10 WIS C, Co Carpers Page 3, Co Carpers Page 3, Co Carpers Co C						_		_	_
Line Cost Centers Col. 4) Col. 1/ Page 3, Page 3, Col. 3, (Col. 3 Col. 5 Col. 4 Col. 5					-	_	•		-
No.					_	•	•		
Impatient Ancillary Cost Centers		Cost Centers	1		•			•	•
1 Operating Room	No.		•	,				· · · · · · · · · · · · · · · · · · ·	Col. 5)
Recovery Room			(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 Infravenous 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 Renat Dialysis 21 AntoLaines 22 Cancer Treatment Ctr. 23 Ultrasound 24 Special Procedures 25 CT ScanMRI 26 Pathology 27 Rehab Medicine 28 Cath Lab 29 ASC 30 Wound Care 31 Pain Management 31 Pain Management 32 Diabetes Center 33 Remail Practice Clinic 34 Employees 35 Niles Infusion Center 36 Mode Parmacy 37 Other 40 Other 41 Other 42 Other 42 Other 43 Cites 44 Emergency 45 Other 46 Other 47 Other 48 Other 49 Other 49 Other 40 Other 41 Other 44 Other 45 Other									
4. Anesthesiology - Diagnostic 6. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory 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. Broug Charged to Patients 19. Trugs Charged to Patients 10. Renal Dialysis 11. Ambulance 12. Cancer Treatment Ctr. 13. Ultrasound 14. Special Procedures 15. OT Scan/MRI 16. Pathology 17. Rehab Medicine 18. An August Charged to Patients 19. Drugs Charged to Patients 19. Drugs Charged to Patients 10. Renal Dialysis 10. Renal Dialysis 11. Ambulance 12. Cancer Treatment Ctr. 13. Ultrasound 14. Special Procedures 15. The Scan/MRI 16. Pathology 17. Rehab Medicine 18. August Charged to Patients 19. ASC 10. August Charged to Patients 10. August Charged The Patients 11. August Charged The Patients 12. August Charged The Patients 13. August Charged The Patients 14. Cancer Charged The Patients 15. August Charged The Patients 16. August Charged The Patients 17. August Charged The Patients 18. August Charged The Patients 18. August Charged The Patients 19. August Charg		-							
S. Radiology - Therapeutic		·							
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. Cancer Treatment Ctr. 23. Ultrasound 24. Special Procedures 25. CT Scan/MRI 26. Pathology 27. Rehab Medicine 28. Gaft Lab 29. ASC 30. Wound Care 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Oliver 36. John Canter 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other 43. Cirrical Conter 44. Emergency 45. Other 46. Other 47. Other 48. Other 49. Other 49. Other 40. Other 41. Other 40. Other 41. Other 42. Other 43. Cirrical Canter 44. Emergency 45. Observation	6.								
9 Blood - Administration 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. Cancer Treatment Ctr. 23. Ultrasound 24. Speeial Procedures 25. CT Scan/MRI 26. ET Scan/MRI 27. Rehab Medicine 28. Cath Lab 29. ASC 30. Wound Care 31. Pain Management 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. JOther 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 41. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	7.	Nuclear Medicine							
10 Blood - Administration	8.	Laboratory							
11. Intravenous Therapy	9.	Blood							
12 Respiratory Therapy									
13 Physical Therapy	11.	Intravenous 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. Cancer Treatment Ctr. 23. Ultrasound 24. Special Procedures 25. CT Scar/MRI 26. Pathology 27. Rehab Medicine 28. Cath Lab 29. JASC 30. Wound Care 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other 44. Emergency 44. Emergency 45. Observation									
15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Cancer Treatment Ctr. 23. Ultrasound 24. Special Procedures 25. CT Scan/MRI 26. Pathology 27. Rehab Medicine 28. Cath Lab 29. ASC 30. Wound Care 31. Pain Management 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 40. Other 41. Other 41. Other 42. Ulter Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 44. Clinic 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. Cancer Treatment Ctr. 23. Ultrasound 24. Special Procedures 25. CT Scan/MRI 26. Pathology 27. Rehab Medicine 28. Cath Lab 29. ASC 30. Wound Care 31. Pain Management 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 38. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic Outpatient Ancillary Cost Centers 44. Emergency 45. Observation	15.	Speech Pathology							
18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis	16.	EKG							
19. Drugs Charged to Patients									
20. Renal Dialysis									
21. Ambulance	19.	Drugs Charged to Patients							
22. Cancer Treatment Ctr. 23. Ultrasound 24. Special Procedures 25. CT Scan/MRI 26. Pathology 27. Rehab Medicine 28. Cath Lab 29. ASC 30. Wound Care 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	20.	Renal Dialysis							
23. Ultrasound 24. Special Procedures 25. CT Scan/MRI 26. Pathology 27. Rehab Medicine 28. Cath Lab 29. ASC 30. Wound Care 31. Pain Management 32. Diabetes Center 33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 38. Other 40. Other 41. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. CIinic 44. Emergency 45. Observation	21.	Ambulance							
24. Special Procedures	22.	Cancer Treatment Ctr.							
25. CT Scan/MRI	23.	Ultrasound							
26. Pathology	24.	Special Procedures							
27. Rehab Medicine	25.	CT Scan/MRI							
28. Cath Lab 9. ASC 30. Wound Care 9. Search State Stat	26.	Pathology							
29. ASC Wound Care 30. Wound Care Section 1 31. Pain Management Section 2 32. Diabetes Center Section 3 33. Family Practice Clinic Section 3 34. Implant Devices Section 3 35. Niles Infusion Center Section 3 36. 340B Pharmacy Section 3 37. Other Section 3 38. Other Section 3 40. Other Section 3 41. Other Section 4 42. Other Section 4 43. Clinic Section 4 44. Emergency Section 4 45. Observation Section 5	27.	Rehab Medicine							
30. Wound Care	28.	Cath Lab							
31. Pain Management	29.	ASC							
32. Diabetes Center	30.	Wound Care							
33. Family Practice Clinic 34. Implant Devices 35. Niles Infusion Center 36. 340B Pharmacy 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	31.	Pain Management							
34. Implant Devices	32.	Diabetes Center							
35. Niles Infusion Center 9<	33.	Family Practice Clinic							
36. 340B Pharmacy 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation	34.	Implant Devices							
37. Other	35.	Niles Infusion Center							
38. Other	36.	340B Pharmacy							
39. Other									
39. Other	38.	Other							
41. Other									
42. Other Outpatient Ancillary Cost Centers 43. Clinic Semergency 44. Emergency Separation	40.	Other							
Outpatient Ancillary Cost Centers 43. Clinic ————————————————————————————————————	41.	Other							
43. Clinic									
44. Emergency		Outpatient Ancillary Cost Centers							
45. Observation	43.		1						
	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

110111111111					
Medicare Provider Number:		Medicaid	Provider Number:		
	14-0114			3056	
Program:		Period Co	vered by Statement:		
Medicaid Hospital		From:	01/01/2023	To:	12/31/2023

			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.	Special Care Nursery							
54.	Other							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Rev. 10 / 11

Computation of Lesser of Reasonable Cost or Customary Charges

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Pre	lin	nir	191	rv

Medicare Provider Number:	Medicaid Provider Number:
14-0114	3056
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient
1	Ancillary Services		(2)
	(BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services		
	(BHF Page 4, Line 25)	268,575	
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)	5	
7.	Total Reasonable Cost of Covered Services		
	(Sum of Lines 1 through 6)	268,580	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost		
	(Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

			T
l	0	Program	Program
Line	Customary Charges	Inpatient	Outpatient
No.		(1)	(2)
9.	Ancillary Services		
	(See Instructions)	470,951	
10.	Inpatient Routine Services		
	(Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	431,538	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Special Care Nursery		
	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)	902,489	
13.	Excess of Customary Charges Over Reasonable Cost		
	(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		633,909
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:	
14-0114	3056	
Program:	Period Covered by Statement:	,
Medicaid Hospital	From: 01/01/2023 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)	268,580	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	268,580	
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)	268,580	

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 Provider Number:	
14-0114	3056	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 01/01/2023 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)	633,909		
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)					

Teaching Physicians / Routine Services Questionnaire

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Medicare Provider Number:	Medicaid Provider Number:	
14-0114	3056	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 01/01/2023 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)	1

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)
Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
Program outpatient cost (Line 5 X Line 3) (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				l
	(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)				

1 Telliminar y					
Medicare Provider Number:	Medicaid Provider Number:				
14-0114	3056				
Program:	Period Covered by Statement:				
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023				

							1	
			Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
		GME	Charges	GME	Program	Program	Program	Program
		Cost	(CMS 2552-10	Cost	Charges	Charges	Expenses	Expenses
		(CMS 2552-10	W/S C,	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.		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	137,055	181,175,742	0.000756	6,536	, ,	5	, ,
	Recovery Room							
	Delivery and Labor Room	137,055	24,644,051	0.005561				
	Anesthesiology	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , ,					
	Radiology - Diagnostic							
	Radiology - Therapeutic							
	Nuclear Medicine							
	Laboratory							
	Blood							
	Blood - Administration							
	Intravenous Therapy							
	Respiratory Therapy							
	Physical Therapy							
	Occupational Therapy							
	Speech Pathology							
	EKG							
	EEG							
	Med. / Surg. Supplies							
	Drugs Charged to Patients							
	Renal Dialysis							
	Ambulance							
	Cancer Treatment Ctr.							
	Ultrasound							
	Special Procedures							
	CT Scan/MRI							
	Pathology							
	Rehab Medicine							
	Cath Lab							
	ASC							
	Wound Care							
	Pain Management							
	Diabetes Center	+						
	Family Practice Clinic	+						
	Implant Devices	+						
	Niles Infusion Center	+						
	340B Pharmacy	+						
	Other	+						
	Other	+						
	Other	+						
	Other	+						
	Other	+						
	Other	+						
42.	Outpatient Ancillary Centers							333333333333
13	Clinic	<u> </u>	<u> </u>	***************************************	<u> </u>		************	<u> </u>
	Emergency	1,710,881	149,721,674	0.011427				
	Observation	1,7 10,001	148,121,014	0.011427				
	Ancillary Total		***********		 	 		
40.	Anchiary Total	6 000000000000000000000000000000000000	<u> </u>	000000000000000000000000000000000000000		<u> </u>	5	

^{*} 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)

Medicare Provider Number:			Medicaid Provider Number:			
	14-0114			3056		
Program:		Period Cov	vered by Statement:			
Medicaid Hospital		From:	01/01/2023	To:	12/31/2023	

		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	6,358,440	44,721	142.18				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	589,030	2,412	244.21				
52.	Coronary Care Unit							
53.	Special Care Nursery							
54.	Other							
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)							
68.	Ancillary Total (from line 46)						5	
69.	Total (Lines 67-68)	100000000000000000000000000000000000000					5	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Pro			

Medicare Provider Number:	Medicaid Provider Number:			
14-0114	3056			
Program:	Period Covered by Statement:			
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023			

Inpatient Reconciliation Records Adjustments Control Adult Days 213 213 Newborn Days 1,714,102 (811,613) Total Inpatient Revenue 1,714,102 (811,613) Ancillary Revenue 807,328 (336,377)	213 213 902,489 470,951
Newborn Days 1,714,102 (811,613)	902,489 470,951
Total Inpatient Revenue 1,714,102 (811,613)	470,951
	470,951
Ancillary Revenue 807 328 (336 377)	·
(000,017)	404 500
Routine Revenue 906,774 (475,236)	431,538
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 Part I-Hospital IP days to agree with W/S S-3 of the Medicare report	
BHF Page 3 - IP charges reported are the 2022 cost reported charges; adjusted the IP charges to agree with the IPCR since the Part II-Program days also agree with the IPCR	
BHF Page 3 - Combined the Implants with the Med/Surg Supplies as the IPCR doesn't differentiate between them	
BHF Page 7 - Adjusted the Routine charges to agree with the IPCR as 2022 charges reported on the 2023 cost report BHF Supplemental 2a and 2b - GME costs were added to agree with W/S B, Part 1, column 25 of the Medicare report	
Minor rounding adjustment	
	-