General Information	Preliminary				
Name of Hospital:		Me	dicare Provid	er Number:	
Advocate Christ Hospital					14-0208
Street:		Me	dicaid Provide	er Number:	45000
4440 West 95th Street City:	State:		Zip:		15008
Oak Lawn	Illinois		p.	60453	
Period Covered by Statement:	From:		To:		
Type of Control	01/01/2023			12/31/2023	
Voluntary Nonprofit	Proprietary	Government	(Non-Federal)		
XXXX Church	Individual	Sta	ite		Township
Corporation	Partnership	City	у		Hospital District
Other (Specify)	Corporation	Cou	unty		Other (Specify)
Type of Hospital					
XXXX General Short-Term XXXX	Psychiatric			Cancer	
General Long-Term	Rehabilitation			Other (Sp	pecify)
Health Care Program	(A Separate Report Must E	Be Filled Out Fo	or Each Distin	ct Part Unit)	
XXXX Medicaid Hospital XXXX	Medicaid Sub II Rehab				
Medicaid Sub I Psych	Medicaid Sub III Other	l 		<u> </u>	
By Fine And / Or Imprisonr	ion Or Falsification Of Any Information ment Under Federal Law ADMINISTRATOR OF PROVIDER(S):	In This Cost Re	eport May Be	Punishable	
CERTIFICATION BT OFFICER OR	ADMINISTRATOR OF PROVIDER(3).				
Sheet and Statement of Revenue ar for the cost report beginning 01/	nd the above statement and that I have example the department of the statement and that I have example the statement and t	s) and number(s) d that to the besi)) <u>Advoc</u> t of my knowle	ate Christ Hos dge and belief	pital 15008 f, it is a true, correct and
complete statement prepared from t	the books and records of the provider in ac	ccordance with a	ipplicable instri	uctions, excep	ot as noted.
Prepared by (Signed):		Signed	I (Officer or Ad	ministrator of	Provider(s)):
N (T		NI //II	iu \		
Name (Typewritten) Title	Date	Name (1 Title	ypewritten)		
Firm		Date			
Telephone Number			ne Number		
Email Address		Email A	ddress		

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.

Pre	lir	niı	nar

1 Temminar y	
Medicare Provider Number:	Medicaid Provider Number:
14-0208	15008
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 01/01/2023 To: 12/31/2023

					Total	Percent		Number Of	Average
					Inpatient	Of	Number	Discharges	Length Of
			Tatal	Tatal			Of	-	-
	Impationt Statistics	T-4-1	Total	Total	Days	Occupancy		Including	Stay By
l l	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	469	171,185		156,047	91.16%		30,787	6.16
	Psych	32	11,680		5,173	44.29%		675	7.66
	Rehab	37	13,505		9,581	70.94%		695	13.79
	Other (Sub)								
	Intensive Care Unit	129	47,085		33,718	71.61%			
	Coronary Care Unit								
	Other								
	Other								
9. (Other								
10. 0	Other								
11. (Other								
12. 0	Other								
	Other								
	Other								
	Other								
	Other								
	Other								
	Other								
	Other Other								
	Newborn Nursery	40	14,600		15 106	104.01%			
	,				15,186			20.457	c 20
	Total Observation Bed Days	707	258,055		219,705	85.14%		32,157	6.36
23. 0	Observation Bed Days								
					18,736				
		(4)	(0)	(0)	,	(5)	(0)	(7)	(0)
	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	(1)	(2)	(3)	,	(5)	(6)	(7) 1,136	(8) 6.76
1. A	Adults and Pediatrics Psych	(1)	(2)	(3)	(4)	(5)	(6)		
1. <i>F</i> 2. F 3. F	Adults and Pediatrics Psych Rehab	(1)	(2)	(3)	(4)	(5)	(6)		
1. A 2. F 3. F 4. (Adults and Pediatrics Psych Rehab Other (Sub)	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. (Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit	(1)	(2)	(3)	(4)	(5)	(6)		
1. A 2. F 3. F 4. C 5. I	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. (5. I 6. (7. (Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. (5. I 6. (7. (8. (9. (Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. (5. I 6. (7. (8. (9. (Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. / 2. F 3. F 4. 0 5. I 6. 0 7. 0 8. 0 9. 0	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. (5. I 6. (7. (8. (9. (11. (11. (Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other Other Other Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. II 6. C 7. C 8. C 9. C 10. C 11. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other Other Other Other Other Other Other Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 10. C 11. C 12. C 13. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 10. C 11. C 12. C 13. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 10. C 11. C 12. C 13. C 14. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 10. C 12. C 13. C 14. C 16. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 10. C 11. C 12. C 14. C 16. C 17. C	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 9. C 10. C 11. C 12. C 14. C 16. C 17. C 18. C 19. C 19	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	(5)	(6)		
1. A 2. F 3. F 4. G 5. I 6. G 7. G 8. G 9. G 10. G 11. G 12. G 14. G 16. G 17. G 18. G 19.	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860 2,824	(5)	(6)		
1. A 2. F 3. F 4. C 5. I 6. C 7. C 8. C 9. C 11. C 12. C 13. C 14. C 17. C 18. C 19. C 20. C 21. N	Adults and Pediatrics Psych Rehab Other (Sub) Intensive Care Unit Coronary Care Unit Other	(1)	(2)	(3)	(4) 4,860	3.74%	(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 Cililliai y			
Medicare Provider Number:		Medicaid Provider Number:	
	14-0208	15008	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2023 To: 12/31/2023	١.

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	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)
1.	Operating Room	128,562,168	380,251,295	0.338098	6,239,081		2,109,421	
2.	Recovery Room	15,573,765	55,482,860	0.280695	347,070		97,421	
3.	Delivery and Labor Room	17,668,383	55,498,479	0.318358	1,769,775		563,422	
4.	Anesthesiology	3,874,026	86,146,983	0.044970	1,504,617		67,663	
5.	Radiology - Diagnostic	77,991,393	652,421,513	0.119541	10,398,847		1,243,089	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	61,642,637	350,426,726	0.175907	8,040,629		1,414,403	
	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	34,619,939	134,949,025	0.256541	2,992,380		767,668	
13.	Physical Therapy	33,233,665	130,144,037	0.255361	1,878,923		479,804	
	Occupational Therapy							
	Speech Pathology							
	EKG	10,457,771	94,276,607	0.110926	1,306,645		144,941	
	EEG	2,314,595	7,534,890	0.307184	189,435		58,191	
	Med. / Surg. Supplies	81,276,361	193,457,928	0.420124	4,249,181		1,785,183	
	Drugs Charged to Patients	95,080,203	741,024,211	0.128309	14,511,084		1,861,903	
	Renal Dialysis	5,886,168	17,155,280	0.343111	271,340		93,100	
	Ambulance		, ,		,		,	
22.	Implantable Devices	94,883,381	276,815,710	0.342767	5,333,811		1,828,254	
	Dev Eval		, ,					
	Cardiac Rehab	1,891,988	4,895,815	0.386450				
	Ambulatory Care	63,531,129		0.476097	3,205		1,526	
	Kidney Acquisition	4,095,339	1,403,740	2.917448	,		, -	
	Heart Acquisition	8,984,028	2,420,469	3.711689				
	Lung Acquisition	-,,-	, , ,					
29.	Other							
	Other							
	Other	1	İ					
32.	Other							
33.	Other							
34.	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
	Emergency	60,134,847	273,537,201	0.219842	3,048,415		670,170	
	Observation	24,269,865	72,063,339	0.336785	418,935		141,091	
	Total	_ :,_55,550	. =, : 30,000	2.200.00	62,503,373		13,327,250	

^{*} 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 Preliminary

BHF Page 4

Medicare Provider Number: Medicaid Provider Number:					
14-0208	15008				
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)	226,407,054	6,586,494	11,177,918	
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	174,783	5,173	9,581	
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	1,295.36	1,273.24	1,166.68	
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)	4,860			
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)	6,295,450			
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)	6,295,450			

Line		Total Dept. Costs (CMS 2552-10,	Total Days (CMS 2552-10, W/S S-3,	Average Per Diem	Program Days (BHF Page 2,	Program Cost
No.	Description	W/S C, Pt. 1, Col. 1)	,	(Col. A / Col. B)	Part II, Col. 4)	(Col. C x Col. D)
	·	(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	92,726,982	33,718	2,750.07	2,824	7,766,198
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	22,546,768	15,186	1,484.71	542	804,713
24.	Program inpatient ancillary care service cost					10.007.050
	(BHF Page 3, Col. 6, Line 46)	-				13,327,250
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					28,193,611

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:
14-0208	15008
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 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)						

	Hospital Outpatient Services	Percent of Assign- able Time (CMS 2552-10,	Expense Alloca- tion (CMS 2552-10,	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1,	Ratio of Cost to Charges	(BHF I	Charges Page 3, ines 43-45)	•	Expenses 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 Tellilliai y					
Medicare Provider Number:		Medicaid Pr	rovider Number:		
14	-0208			15008	
Program:		Period Cove	ered by Statement:		
Medicaid-Hospital		From:	01/01/2023	To:	12/31/2023

Line			Professional Component	Total Dept. Charges (CMS 2552-10,	Ratio of Professional Component	Inpatient Program Charges	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
No.					_				for H B P
Inpatient Ancillary Cost Centers (1) (2) (3) (4) (5) (6) (7) 1. Operating Room 2. Recovery Room 3. Delivery and Labor Room 4. Anesthesiology 5. Radiology - Delapostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Bibord 10. Bibood - 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. Implantable Devices 22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 30. Other 31. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. O		Cost Centers			•			•	(Col. 3 X
1. Operating Room									
Recovery Room			(1)	(2)	(3)	(4)	(5)	(6)	(7)
3. Delivery and Labor Room									
4. Anesthesiology Section Sect									
5. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 9.									
6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood									
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 1	5.	Radiology - Diagnostic							
B. Laboratory 9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Docupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Pa									
9 Blood									
10 Blood - Administration									
11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. D									
12 Respiratory Therapy									
13. Physical Therapy		1,7							
14. Occupational Therapy 15. Speech Pathology 16. EKG 8 17. EEG 9 18. Med. / Surg. Supplies 9 19. Drugs Charged to Patients 9 20. Renal Dialysis 9 21. Ambulance 9 22. Implantable Devices 9 23. Dev Eval 9 24. Cardiac Rehab 9 25. Ambulatory Care 9 26. Kidney Acquisition 9 27. Heart Acquisition 9 28. Lung Acquisition 9 30. Other 9 31. Other 9 32. Other 9 33. Other 9 34. Other 9 35. Other 9 36. Other 9 37. Other 9 38. Other 9 39. Other 9 40. Other 9 41. Other 9 42. Other 9 43. Clinic 9 44. Emergency 9	12.	Respiratory I nerapy							
15. Speech Pathology									
16. EKG									
17. EEG									
18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 41. Other 44. Other 44. Emergency 45. Observation									
19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 41. Other 41. Other 44. Other 44. Cilinic 44. Emergency 44. Emergency 45. Observation									
20. Renal Dialysis 21. Ambulance 22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
21. Ambulance 22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
22. Implantable Devices 23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39.									
23. Dev Eval 24. Cardiac Rehab 25. Ambulatory Care 25. Kidney Acquisition 27. Heart Acquisition 8. Lung Acquisition 29. Other 9. Other 31. Other 9. Other 32. Other 9. Other 33. Other 9. Other 34. Other 9. Other 35. Other 9. Other 36. Other 9. Other 37. Other 9. Other 38. Other 9. Other 39. Other 9. Other 40. Other 9. Other 41. Other 9. Other 42. Other 9. Other 43. Clinic 9. Other 45. Observation 9. Other other 45. Observation 9. Other									
24. Cardiac Rehab 25. Ambulatory Care 26. Kidney Acquisition									
25. Ambulatory Care 26. Kidney Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 45. Observation									
26. Kidney Acquisition 27. Heart Acquisition 27. Heart Acquisition 28. Lung Acquisition 29. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 40. Other 41. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
27. Heart Acquisition									
28. Lung Acquisition 29. Other 30. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 40. Other 41. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
30. Other 31. Other 32. Other 33. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
31. Other 32. Other 33. Other 34. Other 35. Other 37. Other 38. Other 39.									
32. Other 33. Other 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									
33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39.							<u> </u>		
34. Other									
35. Other									
36. Other 37. Other 38. Other 39. Other 39. Other 40. Other 41. Other 42. Other 42. Other 43. Clinic 44. Emergency 45. Observation 45. Observation 46. Other 47. Other 48. Other 49. Other									
37. Other									
38. 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									
42. Other Outpatient Ancillary Cost Centers 43. Clinic Emergency 45. Observation Observation									
Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 5. Observation						İ	İ	İ	
43. Clinic 44. Emergency 45. Observation									
44. Emergency 45. Observation									
45. Observation									
46 Ancillan, Total									
40. Anchiary Total	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 Preliminary

BHF Page 6(b)

1 Tellilliai y					
Medicare Provider Number:		Medicaid I	Provider Number:		
	14-0208			15008	
Program:		Period Co	vered by Statement:		
Medicaid-Hospital		From:	01/01/2023	To:	12/31/2023

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, 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							
48.	Psych							
	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
	Other							
65.	Other							
	Nursery							
	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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(Sum of Lines 1 through 6)

8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)

Medicare Provider Number: 14-0208		Medicaid Provider Number: 15008				
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/2023 To: 12/31/2023				
	medicalu-nospital	10m. 01/01/2020 1	0. 12/3/1/2023	_		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	_		
1	Ancillary Services	(1)	(2)	_		
٠.	(BHF Page 3, Line 46, Col. 7)					
2.	Inpatient Operating Services (BHF Page 4, Line 25)	28,193,611				
	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)	1,047,183				
7.	Total Reasonable Cost of Covered Services					

29,240,794 100.00%

Line	Customary Charges	Program Inpatient	Program Outpatient
No.		(1)	(2)
9.	Ancillary Services		
	(See Instructions)	62,503,373	
10.	Inpatient Routine Services		
	(Provider's Records)		
	A. Adults and Pediatrics	17,333,873	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	10,828,379	
	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	2,175,302	
11	Services of Teaching Physicians		
	(Provider's Records)		
12.	Total Charges for Patient Services		
	(Sum of Lines 9 through 11)	92,840,927	
13	Excess of Customary Charges Over Reasonable Cost	52,510,621	
	(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		63,600,133
14	Excess of Reasonable Cost Over Customary Charges	 	33,330,100
1-7.	(Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15	Excess Reasonable Cost Applicable to Inpatient and Outpatient		
13.	(Line 8, Each Column X Line 14)		
	(Line 0, Laur Column A Line 14)		

1 reminury				
Medicare Provider Number:	Medicaid Provider Number:			
14-0208	15008			
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)	29,240,794	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	29,240,794	
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)	29,240,794	

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)		

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

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Preliminary

Medicare Provider Number:	Medicaid Provider Number:				
14-0208	15008				
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)	63,600,133		
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)						

Tremmary			
Medicare Provider Number:	Medicaid Provider Number:		
14-0208	15008		
Program:	Period Covered by Statement:		
Modicaid-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

Tartin Goot of Frigorolano Biroot incurca	and bargiour borvious
 Physicians on hospital staff average per dier 	
(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)
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)				
l	(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 i Chiminai y					
Medicare Provider Number:		Medicaid	Provider Number:		
	14-0208			15008	
Program:		Period Co	vered by Statement:		
Medicaid-Hospital		From:	01/01/2023	To:	12/31/2023

1. O 2. Re 3. De 4. Ar 5. Re 6. Re 7. Ne 8. Le 9. De 11. In 12. Re 13. Pi 14. Oc 15. Sp 16. El 17. El 18. M 19. De 20. Re 21. Ar 22. Im 23. De 24. Ce	Blood - Administration ntravenous Therapy	(1) 6,088,699 262,132	(2) 380,251,295 86,146,983	0.016012 0.003043	(4) 6,239,081	(5)	(6) 99,900	(7)
2. Ro 3. Do 4. Ar 5. Ro 6. Ro 7. No 8. Lo 9. Bi 11. In 12. Ro 13. Pi 14. Oo 15. Sp 16. El 17. El 18. M 19. Do 20. Ro 21. Ar 22. Im 23. Do 24. Co	Recovery Room Delivery and Labor Room Anesthesiology Radiology - Diagnostic Radiology - Therapeutic Ruclear Medicine Raboratory Blood Blood - Administration Intravenous Therapy						99,900	
3. Do 4. Ar 5. Ri 6. Ri 7. Ni 8. Le 9. Bi 10. Bi 11. In 12. Ri 13. Pi 14. Oo 15. Si 16. Ei 17. Ei 18. M 19. Do 20. Ri 22. In 23. Do 24. Ci	Delivery and Labor Room Anesthesiology Radiology - Diagnostic Radiology - Therapeutic Ruclear Medicine Raboratory Blood Blood - Administration Intravenous Therapy	262,132	86,146,983	0.003043				
4. Ar 5. Ra 6. Ra 7. Nr 8. La 9. Bi 10. Bi 11. In 12. Ra 13. Pi 14. Or 15. Sp 16. Ei 17. Ei 18. Mr 19. Dr 20. Ra 21. Ar 22. Irr 23. Do 24. Ca	Anesthesiology Radiology - Diagnostic Radiology - Therapeutic Ruclear Medicine Raboratory Rlood Rlood - Administration Paravenous Therapy	262,132	86,146,983	0.003043				
5. Ri 6. Ri 7. Ni 8. La 9. BI 10. BI 11. In 12. Ri 13. Pi 14. Oi 15. Si 16. Ei 17. Ei 18. M 19. Di 20. Ri 21. Ar 22. Im 23. Di 24. Ci	Radiology - Diagnostic Radiology - Therapeutic Ruclear Medicine Raboratory Rlood Rlood - Administration Paravenous Therapy	202,132	00,140,963	0.003043	1 504 617		4.570	
6. Ri 7. Ni 8. La 9. Bi 10. Bi 11. In 12. Ri 13. Pi 14. Oi 15. Sp 16. Ei 17. Ei 19. Di 20. Ri 22. In 23. Di 24. Ci	Radiology - Therapeutic Juclear Medicine				1,504,617		4,579	
7. No. 8. La 9. Bl 10. Bl 11. In 12. Ro 13. Pl 14. Oo 15. Sp 16. El 17. El 17. El 19. Do 20. Ro 21. Ar 22. Ir 23. Do 24. Ca 24. Ca 15. No. Bl 16. Ca	Juclear Medicine aboratory Blood Blood - Administration ntravenous Therapy							
8. La 9. Bi 10. Bi 11. In 12. Re 13. Pi 14. Or 15. Sp 16. El 17. El 18. M 19. Or 20. Re 21. Ar 22. In 23. Do 24. Ca	aboratory Blood Blood - Administration ntravenous Therapy							
9. Bi 10. Bi 11. In 12. Re 13. Pi 14. Oc 15. Si 16. Ei 17. Ei 18. M 19. Dr 20. Re 21. Ar 22. In 23. Do 24. Cc	Blood Blood - Administration ntravenous Therapy							
10. Bi 11. In 12. Re 13. Pi 14. O 15. Si 16. Ei 17. Ei 18. M 19. Di 20. Re 21. Ar 22. In 23. De 24. Ce	Blood - Administration ntravenous Therapy							
11. In 12. Ro 13. Pi 14. Oo 15. Si 16. Ei 17. Ei 18. M 19. Do 20. Ro 21. Ar 22. Im 23. Do 24. Co	ntravenous Therapy							
12. Ro 13. Pi 14. O 15. Si 16. El 17. El 18. M 19. Di 20. Ro 21. Ar 22. Im 23. Do 24. Ca								
13. Pi 14. O 15. Si 16. El 17. El 18. M 19. Di 20. Re 21. Ai 22. Im 23. Do 24. Ca								
14. O 15. Sp 16. Et 17. Et 18. M 19. Do 20. Ro 21. Ar 22. Im 23. Do 24. Co	Respiratory Therapy							
15. Sp 16. EH 17. EH 18. M 19. Do 20. Ro 21. Ar 22. Im 23. Do 24. Co	Physical Therapy							
16. Ei 17. Ei 18. M 19. Di 20. Re 21. Ar 22. Im 23. De 24. Ca	Occupational Therapy							
17. Ef 18. M 19. Di 20. Re 21. Ar 22. Im 23. De 24. Ca	Speech Pathology							
18. M 19. Di 20. Re 21. Ar 22. Im 23. Do 24. Ca								
19. Di 20. Ro 21. Ar 22. Im 23. Do 24. Co								
20. Re 21. Ar 22. Im 23. De 24. Ca	Med. / Surg. Supplies							
21. Ar 22. Im 23. De 24. Ca	Orugs Charged to Patients							
22. lm 23. De 24. Ca	Renal Dialysis							
23. De 24. Ca	mbulance							
24. Ca	mplantable Devices							
	Dev Eval							
	Cardiac Rehab							
25. Ar	mbulatory Care							
26. Ki	(idney Acquisition							
27. He	leart Acquisition							
28. Lu	ung Acquisition							
29. O	Other							
30. O	Other							
31. O	Other							
32. O	Other							
	Other							
34. O	Other							
35. O								
	Other							
37. O								
	Other							
	Other							
	Other							
41. O								
42. O								
43. CI	Other							
	Other Outpatient Ancillary Centers							
	Other Outpatient Ancillary Centers Dinic	6,606,686	273.537 201	0.024153	3.048 415		73 628	
46. A ı	Other Outpatient Ancillary Centers	6,606,686	273,537,201	0.024153	3,048,415		73,628	

^{*} 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: 14-0208 15008 Period Covered by Statement: From: 01/01/2023 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)	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	19,012,955	174,783	108.78	4,860		528,671	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
	Intensive Care Unit	4,064,358	33,718	120.54	2,824		340,405	
	Coronary Care Unit							
	Other							
	Other							
55.	Other							
	Other							
57.	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Nursery							
	Routine Total (lines 47-66)						869,076	
	Ancillary Total (from line 46)						178,107	
69.	Total (Lines 67-68)						1,047,183	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary	
Medicare Provider Number:	Medicaid Provider Number:
14-0208	15008
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 01/01/2023 To: 12/31/2023

7,684		
7,001		7,684
542		542
93,112,266	(271,339)	92,840,927
62,774,712	(271,339)	62,503,373
30,337,554		30,337,554
		_
		_
	S-3 of the Medicare report	
e & Children's see attached	d spreadsheet	
	ttached	
	93,112,266 62,774,712 30,337,554 alt report to agree with W/S L Medicaid purposes. e & Children's see attached to the IPCR	93,112,266 (271,339) 62,774,712 (271,339) 30,337,554 alt report to agree with W/S S-3 of the Medicare report L Medicaid purposes. e & Children's see attached spreadsheet