General Information	Preliminary				
Name of Hospital: Holy Family Medical Center		Medicare Provider Number:	14-2011		
Street: 100 North River Road		Medicaid Provider Number:	4013		
City:	State:	Zip:	4013		
Des Plaines	Illinois	60016			
Period Covered by Statement:	From: 07/01/2022	To: 06/30/2023			
Type of Control		•			
Voluntary Nonprofit	Proprietary Gov	vernment (Non-Federal)	_		
XXXX Church	Individual	State	Township		
Corporation	Partnership	City	Hospital District		
Other (Specify)	Corporation	County	Other (Specify)		
Type of Hospital					
General Short-Term	Psychiatric	Cancer			
XXXX General Long-Term	Rehabilitation	Other (Sp	pecify)		
Health Care Program	(A Separate Report Must Be Fill	led Out For Each Distinct Part Unit)			
XXXX Medicaid Hospital	Medicaid Sub II Rehab	_ 🗆 =	<u></u>		
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)) Holy Family Medical Center 4013 for the cost report beginning 07/01/2022 and ending 06/30/2023 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.

Pro	1.	•	

1 Temmat y	
Medicare Provider Number:	Medicaid Provider Number:
14-2011	4013
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

Inpatient Statistics						Total	Percent		Number Of	Average
Inpatient Statistics								Number		Length Of
Inpatient Statistics				Total	Total	•	_			Stay By
Line Beds Ayailable Days Room Private Divided By Colled By Recluding Excluding Excluding Factor Recluding Private Divided By Colled By Recluding Recluding Private Pri		Innationt Statistics	Total			-			_	Program
No.	1 :	inpatient Statistics				_	•			-
Part I-Hospital				_				_		Excluding
1, Adults and Pediatrics	NO.	Dowt I Hoowital					Column 2)			Newborn
2. Psych 3. Rehab 4. Other (Sub) 5. Intensive Care Unit 6. Coronary Care Unit 7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 19. Other 10. Other 11. Other 11. Other 12. Other 13. Other 14. Other 15. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery 22. Total 23. Observation Bed Days Part II-Program 10. Other 11. Adults and Pediatrics 12. Psych 13. Other 14. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 19. Other 19. Other 21. Intensive Care Unit 22. Psych 3. Rehab 4. Other (Sub) 5. Intensive Care Unit 7. Other 8. Other 9. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Coronary Care Unit 7. Other 17. Other 18. Other 19.	_		\ /		(3)			(6)	\ /	(8)
3. Rehab 4. Other (Sub) 5. Intensive Care Unit 6. Coronary Care Unit 7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 17. Other 18. Other 19. Other 10. Other 19. Other 10. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 20. Other 21. Newborn Nursery 22. Total and Pediatrics 23. Observation Bed Days Part II-Program (1) (2) (3) (4) (5) (6) (7) (7) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	1.	Adults and Pediatrics	120	43,800		25,054	57.20%		731	37.47
4. Other (Sub) 5. Intensive Care Unit 6. Coronary Care Unit 7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 10. Other 11. Other 11. Other 12. Other 13. Other 14. Other 15. Other 17. Other 18. Other 19. Other 19. Other 19. Other 10. Other 10. Other 11. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 10. Other 10. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 17. Other 18. Other 19. Other 19. Other 10. Other 11. Adults and Pediatrics 10. Other 11. Adults and Pediatrics 11. Other 12. Other 13. Other 14. Other (Sub) 15. Intensive Care Unit 16. Other 17. Other 17. Other 19. Other 19. Other 11. Other 11. Other 11. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 17. Other 18. Other 19. Other 19. Other 11. Other 11. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
S. Intensive Care Unit 8 2,920 2,340 80.14%										
6. Coronary Care Unit				0.000		0.040	00.440/			
7. Other 8. Other 9. Other			8	2,920		2,340	80.14%			
B. Other 9 Other 10 Other 11 Other 12 Other 13 Other 14 Other 15 Other 15 Other 16 Other 17 Other 17 Other 18 Other 19 Other 19 Other 19 Other 19 Other 19 Other 10 Other 11 Other 11 Other 12 Other 13 Other 14 Other 15 Other 15 Other 15 Other 16 Other 17 Other 17 Other 18 Other 19 Other 19 Other 11 Other 12 Other 12 Other 13 Other 14 Other 15 Other										
9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 16. Other 17. Other 18. Other 19. O										
10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 19. Other 12. Other 12. Other 19.	8.	Other								
11 Other 12 Other 13 Other 14 Other 15 Other 16 Other 17 Other 18 Other 19 Other 19 Other 19 Other 19 Other 10 Other 11 Other 12 Other 13 Other 15 Other 15 Other 15 Other 16 Other 17 Other 17 Other 18 Other 19 Other 19 Other 19 Other 19 Other 10										
12. Other 13. Other 14. Other 16. Other 17. Other 18. Other 19.										
13. Other 14. Other 16. Other 17. Other 18. Other 19.			<u> </u>							
14. Other										
16. Other 17. Other 18. Other 19.										
17. Other 18. Other 19.										
18. Other 19. Other 20. Other 21. Newborn Nursery 22. Total 128 46,720 27,394 58.63% 731 23. Observation Bed Days 23. Observation Bed D										
19. Other 20. Other 21. Newborn Nursery 22. Total 128 46,720 27,394 58.63% 731 23. Observation Bed Days 28.63% 27,394 58.63% 731 23. Observation Bed Days 28.63% 27,394 58.63% 27,394										
20. Other 21. Newborn Nursery 22. Total 128 46,720 27,394 58.63% 731 23. Observation Bed Days										
21. Newborn Nursery 128 46,720 27,394 58.63% 731										
22. Total 128 46,720 27,394 58.63% 731										
Part II-Program										
Part II-Program			128	46,720		27,394	58.63%		731	37.47
1. Adults and Pediatrics 1,387 32 2. Psych	23.	Observation Bed Days								
1. Adults and Pediatrics 1,387 32 2. Psych										
2. Psych 3. Rehab 4. Other (Sub) 5. Intensive Care Unit 122 6. Coronary Care Unit 0ther 7. Other 0ther 9. Other 0ther 10. Other 0ther 12. Other 0ther 13. Other 0ther 14. Other 0ther 16. Other 0ther 17. Other 0ther 18. Other 0ther 20. Other 0ther 21. Newborn Nursery 0ther		Part II-Program	(1)	(2)	(3)		(5)	(6)	\ /	(8)
3. Rehab 4. Other (Sub) 5. Intensive Care Unit 6. Coronary Care Unit 7. Other 8. Other 9. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other	1.	Adults and Pediatrics				1,387			32	47.16
4. Other (Sub) 5. Intensive Care Unit 6. Coronary Care Unit 7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 19. Other 20. Other	2.	Psych								
5. Intensive Care Unit 122 6. Coronary Care Unit 122 7. Other 122 8. Other 122 9. Other 122 10. Other 122 11. Other 122 12. Other 122 13. Other 122 14. Other 122 15. Other 122 16. Other 122 17. Other 122 18. Other 122 19. Other 122 20. Other 122 21. Newborn Nursery										
6. Coronary Care Unit 7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 17. Other 19. Other 19. Other 19. Other 19. Other 20. Other 21. Newborn Nursery										
7. Other 8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 17. Other 19. Other 19. Other 19. Other 20. Other 21. Newborn Nursery						122				
8. Other 9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
9. Other 10. Other 11. Other 12. Other 13. Other 14. Other 15. Other 16. Other 17. Other 19. Other 19. Other 20. Other 21. Newborn Nursery										
10. Other 11. Other 12. Other 13. Other 14. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery	8.	Other								
11. Other 12. Other 13. Other 14. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
12. Other 13. Other 14. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
13. Other 14. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
14. Other 16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
16. Other 17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
17. Other 18. Other 19. Other 20. Other 21. Newborn Nursery										
18. Other 19. Other 20. Other 21. Newborn Nursery	16.	Other								
19. Other 20. Other 21. Newborn Nursery										
19. Other 20. Other 21. Newborn Nursery	18.	Other								
20. Other 21. Newborn Nursery										
21. Newborn Nursery										
22. Total 1,509 5.51% 32	21.	Newborn Nursery								•

L	ine			
N	lo.	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

1 i Cilillinai y			
Medicare Provider Number:		Medicaid Provider Number:	
	14-2011	4013	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2022 To: 06/30/202	23

Line No.	Ancillary Service Cost Centers Operating Room	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1) 4,050,430	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2) (3) 0.340981	Total Billed I/P Charges (Gross) for Health Care Program Patients (4) 801,169	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6) 273,183	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
	Recovery Room	4,000,400	11,070,754	0.040301	001,103		270,100	
	Delivery and Labor Room							
	Anesthesiology	23,866	2,598,479	0.009185	176.460		1 601	
			, ,		-,		1,621	
	Radiology - Diagnostic	1,924,533	5,101,047	0.377282	232,509		87,721	
	Radiology - Therapeutic	050.007	101.001	4 000000	10.010		44.400	
	Nuclear Medicine	258,987	194,601	1.330862	10,842		14,429	
	Laboratory	4,575,242	32,806,159	0.139463	1,788,622		249,447	
	Blood							
	Blood - Administration							
	Intravenous Therapy							
	Respiratory Therapy	6,924,180	69,482,577	0.099653	4,016,886		400,295	
	Physical Therapy	4,410,476	16,427,971	0.268474	1,194,573		320,712	
	Occupational Therapy							
	Speech Pathology							
	EKG	254,873	3,104,228	0.082105	132,032		10,840	
	EEG	9,512	96,276	0.098799	2,109		208	
	Med. / Surg. Supplies	4,545,203	11,569,761	0.392852	673,878		264,734	
	Drugs Charged to Patients	8,284,181	64,413,716	0.128609	3,356,835		431,719	
20.	Renal Dialysis	1,658,051	11,001,955	0.150705	441,063		66,470	
	Ambulance							
	CT Scan	355,582	7,704,004	0.046155	234,532		10,825	
	Ultrasound	332,047	4,226,526	0.078563	207,734		16,320	
	MRI							
	Hyberbaric Oxygen	1,340,390	9,670,539	0.138606				
26.	Women's Diag. Ctr.	536,099	2,536,226	0.211377				
27.	Substance Abuse							
28.	Implants	1,837,889	4,695,451	0.391419	314,730		123,191	
29.	Other							
	Other							
31.	Other							
32.	Other							
33.	Other							
	Other							
35.	Other							
	Other							
	Other							
38.	Other							
	Other							
	Other							
	Other							
	Other							
	Outpatient Service Cost Centers							
43.	Clinic	678,097	4,158,103	0.163078				
	Emergency	ĺ		-				
	Observation							
	Total				13,583,974		2,271,715	
	* **				-,,		=,=::,:•	

^{*} 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

Pre	ı;,	ni.	na	***

Medicare Provider Number:	Medicaid Provider Number:
14-2011	4013
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

Program Inpatient Operating Cost

Line		Adults and	Sub I	Sub II	Sub III
No.	Description	Pediatrics	Psych	Rehab	Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of				
	swing bed and private room cost differential) (see instructions)	34,857,784			
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	25,054			
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	1,391.31			
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)	1,387			
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)	1,929,747			
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)	1,929,747			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)		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)
	Intensive Care Unit	6,318,388	2,340	2,700.17	122	329,421
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					
23.	Nursery			_		
24.	Program inpatient ancillary care service cost					
	(BHF Page 3, Col. 6, Line 46)					2,271,715
25.	Total Program Inpatient Operating Costs					
	(Sum of Lines 7 through 24)					4,530,883

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:
14-2011	4013
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

Line No.	Hospital Inpatient Services	Percent of Assign- able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense 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)

1 Tellillillial y		
Medicare Provider Number:	Medicaid Provider Number:	
14-2011	4013	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023	1

		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							
	Recovery Room							
	Delivery and Labor Room							
	Anesthesiology							
5.	Radiology - Diagnostic							
	Radiology - Therapeutic							
	Nuclear Medicine							
	Laboratory							
	Blood Administration							
	Blood - Administration Intravenous Therapy							
	1,7							
12.	Respiratory Therapy Physical Therapy							
	Occupational Therapy							
	Speech Pathology							
	EKG							
	EEG							
	Med. / Surg. Supplies							
	Drugs Charged to Patients							
	Renal Dialysis							
	Ambulance							
	CT Scan							
	Ultrasound							
24.	MRI							
	Hyberbaric Oxygen							
	Women's Diag. Ctr.							
27.	Substance Abuse							
28.	Implants							
29.	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other	1						
	Other							
	Other							
42.	Other							
40	Outpatient Ancillary Cost Centers							
	Clinic Emergency							
	Observation Characteristics							
	Ancillary Total							
40.	Anomaly Iolai						1	

^{*} 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 Tehlihat y	
Medicare Provider Number:	Medicaid Provider Number:
14-2011	4013
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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)
47.	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							
	Other							
	Nursery							
	Routine Total (lines 47-66)							
	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Rev. 10 / 11

rrenni	mary				
Medic	are Provider Number:	Medicaid	Provider Number:		,
	14-2011			4013	
Progra	am:	Period C	overed by Statement:		
	Medicaid Hospital	From:	07/01/2022	To:	06/30/2023

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services	(1)	(2)
	(BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services		
	(BHF Page 4, Line 25)	4,530,883	
	Interns and Residents Not in an Approved Teaching		
	Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
	Hospital Based Physician Services		
	(BHF Page 6, Line 69, Cols. 6 & 7)		
	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)		
7.	Total Reasonable Cost of Covered Services		
	(Sum of Lines 1 through 6)	4,530,883	
	Ratio of Inpatient and Outpatient Cost to Total Cost		
	(Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

9. Ancillary Services (See Instructions) 10. Inpatient Routine Services (Provider's Records) A. Adulys and Pediatrics B. Agulys and B. Bagulys and B. Baguly	Line	Customary Charges	Program Inpatient	Program Outpatient
(See Instructions) 10. Inpatient Routine Services (Provider's Records) A. Adults and Pediatrics B. Psych C. Rehab D. Other (Sub) E. Intensive Care Unit G. Other H. Other I. Other I	No.		(1)	(2)
10. Inpatient Routine Services (Provider's Records) A. Adults and Pediatrics B. Psych C. Rehab D. Other (Sub) E. Intensive Care Unit G. Other H. Other I. Other I. Other I. Other J. Other N. Other O. Other N. Other O. Other N. Other O. Other P. Other O. 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) 13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) Minus Line 12)	9.		40.500.074	
(Provider's Records) A. Adults and Pediatrics B. Psych C. Rehab D. Other (Sub) E. Intensive Care Unit G. Other H. Other I. Other	10	1	13,583,974	
A. Adults and Pediatrics B. Psych C. Rehab D. Other (Sub) E. Intensive Care Unit F. Coronary Care Unit G. Other H. Other I. Other	10.			
B. Psych C. Rehab D. Other (Sub) E. Intensive Care Unit G. Other H. Other H. Other I. Other J. Other K. Other M. Other N. Other O. Other R. Other P. Other Q. Other R. Other T. Nursery 11. Services of Teaching Physicians (Provider's Records) (Provider's Records) 12. Total Charges for Patient Services (Sum of Lines 9 through 11) Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Casonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2)				
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D. Other (Sub) E. Intensive Care Unit 838,005 F. Coronary Care Unit 6. Other		,		
E. Intensive Care Unit F. Coronary Care Unit G. Other H. Other I. Other J. Other K. Other L. Other N. Other N. Other O. Other P. Other P. Other R. Other P. Other S. Other T. Nursery 11. Services of Teaching Physicians (Provider's Records) (Provider's Records) 12. Total Charges for Patient Services (Sum of Lines 9 through 11) Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) 15. Services of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) 16. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2) 17. Sum of Cols. 1 through 12)				
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(Sum of Lines 9 through 11) 23,594,274 13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)	12.			
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)			23.594.274	
(Line 12 Minus Line 7, Sum of Cols. 1 through 2) 14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)	13	Excess of Customary Charges Over Reasonable Cost	==,0001,=:1	
14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		19,063,391
(Line 7, Sum of Cols. 1 through 2, Minus Line 12)	14			10,000,001
(Line 1, Suit of Soil, 1 through L, Millor Line 12)				
I 15 IFYCESS REASONANIE COST ANNICANIE TO INNATIENT AND CHITNATIENT	15	Excess Reasonable Cost Applicable to Inpatient and Outpatient		
(Line 8, Each Column X Line 14)	13.			

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Medicare Provider Number:	Medicaid Provider Number:			
14-2011	4013			
Program:	Period Covered by Statement:			
Medicaid Hospital	From: 07/01/2022	To:	06/30/2023	

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services		
	(BHF Page 7, Line 7, Cols. 1 & 2)	4,530,883	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	4,530,883	
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		
-	Total Allowable Cost		
	(Sum of Lines 3 and 4, Plus or Minus Line 5)	4,530,883	

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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Medicare Provider Number:	Medicaio	d Provider Number:		
14-20	11		4013	
Program:	Period C	overed by Statement:		
Medicaid Hospital	From:	07/01/2022	To:	06/30/2023

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

Line	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed			
No.	Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)			
1.	Excess of Customary Charges Over Reasonable Cost			
	(BHF Page 7, Line 13)	19,063,391		
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 Ended			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)					

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Medicare Provider Number:	Medicaid Provider Number:
14-2011	4013
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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)
Program inpatient days				
(BHF Page 2, Part II, Column 4)				
Program outpatient occasions of service				
(BHF Page 2, Part III, Line 1)				

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

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Medicare Provider Number:		Medicaid F	Provider Number:		
	14-2011			4013	
Program:		Period Cov	vered by Statement:		
Medicaid Hospital		From:	07/01/2022	To:	06/30/2023

1. Operating Room	Line No.	Cost Centers Inpatient Ancillary Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, 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)
3. Delivery and Labor Room	1.	Operating Room							
4 Anesthesiology Sadiology - Diagnostic Sadiology - Diagnostic Sadiology - Diagnostic Sadiology - Therapeutic Sadiology - Diagnostic Sadiology - Diagnostic Sadiology - Diagnostic Sadiology - Sadiology Sadiology - S									
5. 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 20. Renal Dialysis 21. Ambulance 22. The Scann 23. Ultrasound 24. MRI 25. Hyberbaric Oxygen 26. Women's Diag. Ctr. 27. Substance Abuse 28. Implants 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									
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. CT Scan 23. Ultrasound 24. MRI 25. Hyberbaric Oxygen 26. Women's Diag. Ctr. 27. Substance Abuse 28. Implants 29. Other 30. Other 31. Other 31. Other 33. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 30. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other									
T. Nuclear Medicine	5.	Radiology - Diagnostic							
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. CT Scan 23. Ultrasound 24. MRI 25. Hyberbaric Oxygen 26. Women's Diag. Ctr. 27. Substance Abuse 28. Implants 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 39. Other 30. Other 31. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 40. Other 40. Other									
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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. CT Scan 23. Ultrasound 24. MRI 25. Hyberbaric Oxygen 26. Women's Diag. Ctr. 27. Substance Abuse 29. Other 30. Other 31. Other 33. Other 34. Other 35. Other 37. Other 47. Other 47.									
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39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic									
40. Other 41. Other 42. Other Outpatient Ancillary Centers 43. Clinic									
41. Other 42. Other Outpatient Ancillary Centers 43. Clinic			1	-		1		1	
42. Other Outpatient Ancillary Centers 43. Clinic									
Outpatient Ancillary Centers 43. Clinic									
43. Clinic	44.								
	43								
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 G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Prenminary					
Medicare Provider Number:		Medicaid Pro	vider Number:		
14	-2011			4013	
Program:		Period Cover	ed by Statement:		
Medicaid Hospital		From:	07/01/2022	To:	06/30/2023

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)
	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							
	Other							
	Nursery							
	Routine Total (lines 47-66)							
	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Hospital Statement of Cost Reconciliation of Patient Days and Revenue Preliminary

Preliminary						
Medicare Provider Number:	Medicaid Provider Number:					
14-2011	4013					
Program:	Period Covered by Statement:					
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023					

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report			
Adult Days	1,509		1,509			
Newborn Days						
Total Inpatient Revenue	23,926,060	(331,786)	23,594,274			
Ancillary Revenue	13,915,760	(331,786)	13,583,974			
Routine Revenue	10,010,300		10,010,300			
Inpatient Received and Receivable						
Outpatient Reconciliation						
Outpatient Occasions of Service						
Total Outpatient Revenue						
Outpatient Received and Receivable						
Preliminary Audit Adjustments: BHF Page 2 - Part II-Program days and discharges agree with W/S S-3 of the Medicare report BHF Page 3 - Adjusted out the Substance Abuse costs as no associated charges included BHF Page 3 - Adjusted out the Observation charges as no associated costs included BHF Page 3 - I/P charges for Hyperbaric Oxygen, Women's Diag Center and Clinic are adjusted out as no inpatient hospital charges for these cost centers BHF Page 4 - Adjusted the Routine costs to agree with W/S C, Part I, Col 1 of the Medicare report						