Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

Preliminary

Name of Hospital: John H. Stroger Jr. Hospital of Cook County	**Medicare Provider Number:** 14-0124
Street: 1901 W. Harrison St.	**Medicaid Provider Number:** 0001
City: Chicago	**State:** IL / **Zip:** 60612
Period Covered by Statement:	**From:** 12/01/2014 / **To:** 11/30/2015

Type of Contrc

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
☐	Church	☐	Individual	☐	State	☐	Township
☐	Corporation	☐	Partnership	☐	City	☐	Hospital District
☐	Other (Specify)	☐	Corporation	XXXX	County	☐	Other (Specify)

Type of Hospita

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)

XXXX	Medicaid Hospital	☐	Medicaid Sub II Rehab	☐	DHS - Office of Rehabilitation Services
☐	Medicaid Sub I Psych	☐	Medicaid Sub III Other	☐	U of I - Division of Specialized Care for Children

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)) John H. Stroger Jr. Hospital of Cc 0001 for the cost report beginning 12/01/2014 and ending 11/30/2015 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

Name (Typewritten)

Title

Date

Telephone Number

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.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	310	111,456		70,473	63.23%		21,577	4.49
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	32	11,680		7,440	63.70%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,423	48.73%			
8.	SICU	14	5,110		2,649	51.84%			
9.	Trauma ICU	12	4,380		2,489	56.83%			
10.	Neuro ICU	10	3,650		2,480	67.95%			
11.	Neonatal ICU	52	18,980		9,096	47.92%			
12.	Peds ICU	10	3,650		868	23.78%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,490		1,845	19.44%			
22.	**Total**	**474**	**171,316**		**98,763**	**57.65%**		**21,577**	**4.49**
23.	Observation Bed Days				13,268				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				20,993			6,450	5.08
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,057				
6.	Coronary Care Unit								
7.	Burn ICU				397				
8.	SICU				569				
9.	Trauma ICU				1,338				
10.	Neuro ICU				793				
11.	Neonatal ICU				6,035				
12.	Peds ICU				582				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,232				
22.	**Total**				**33,996**	**34.42%**		**6,450**	**5.08**

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

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	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)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	63,010,054	178,344,390	0.353306	28,311,806	10,190,352	10,002,731	3,600,313
2.	Recovery Room	5,480,696	17,138,205	0.319794	1,480,387	1,552,970	473,419	496,630
3.	Delivery and Labor Room	8,148,596	3,935,526	2.070523	1,859,207	38,781	3,849,531	80,297
4.	Anesthesiology	6,140,964	57,724,435	0.106384	11,009,688	3,077,044	1,171,255	327,348
5.	Radiology - Diagnostic	49,244,432	161,303,914	0.305290	10,093,071	17,260,449	3,081,314	5,269,442
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	54,512,168	144,097,896	0.378300	11,689,866	13,208,052	4,422,276	4,996,606
9.	Blood							
10.	Blood - Administration	6,518,002	9,180,456	0.709987	2,060,894	278,581	1,463,208	197,789
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,595,095	6,385,889	1.815737	760,985	270,177	1,381,749	490,570
13.	Physical Therapy	3,837,958	3,401,658	1.128261	231,157	363,572	260,805	410,204
14.	Occupational Therapy	1,457,597	1,611,314	0.904601	132,057	197,726	119,459	178,863
15.	Speech Pathology	1,613,633	1,221,072	1.321489	6,913	201,142	9,135	265,807
16.	EKG	13,930,682	27,570,329	0.505278	3,391,404	1,671,283	1,713,602	844,463
17.	EEG							
18.	Med. / Surg. Supplies	38,238,129	29,447,516	1.298518	4,110,711	1,406,147	5,337,832	1,825,907
19.	Drugs Charged to Patients	115,801,859	132,784,581	0.872103	21,345,062	8,522,493	18,615,093	7,432,492
20.	Renal Dialysis	6,695,845	8,747,720	0.765439	404,356	1,810,524	309,510	1,385,846
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
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 Service Cost Centers							
43.	Clinic	108,690,192	111,914,932	0.971186	246,130	16,091,314	239,038	15,627,659
44.	Emergency	53,825,736	61,143,486	0.880318	2,587,407	10,130,284	2,277,741	8,917,871
45.	Observation	19,100,613	29,435,952	0.648887	1,703,209	4,809,416	1,105,190	3,120,768
46.	**Total**				**101,424,310**	**91,080,307**	**55,832,888**	**55,468,875**

* 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 Cc

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	115,950,083			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	83,741			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,384.63			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	20,993			
3.	Program general inpatient routine cost (Line 1c X Line 2)	29,067,538			
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)	29,067,538			

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	18,940,718	7,440	2,545.80	2,057	5,236,711
9.	Coronary Care Unit					
10.	Burn ICU	4,074,460	1,423	2,863.29	397	1,136,726
11.	SICU	7,834,923	2,649	2,957.69	569	1,682,926
12.	Trauma ICU	11,081,461	2,489	4,452.17	1,338	5,957,003
13.	Neuro ICU	5,934,414	2,480	2,392.91	793	1,897,578
14.	Neonatal ICU	14,691,082	9,096	1,615.11	6,035	9,747,189
15.	Peds ICU	4,250,667	868	4,897.08	582	2,850,101
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,644,063	1,845	2,517.11	1,232	3,101,080
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					55,832,888
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**116,509,740**

Hospital Statement of Cos

Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Progra

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

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)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(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.	Burn ICU						
9.	SICU						
10.	Trauma ICU						
11.	Neuro ICU						
12.	Neonatal ICU						
13.	Peds ICU						
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)						

Line No.	Hospital Outpatient 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 Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component 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 H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	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 - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
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							
44.	Emergency							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

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							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	SICU							
55.	Trauma ICU							
56.	Neuro ICU							
57.	Neonatal ICU							
58.	Peds ICU							
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)**							

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		55,468,875
2.	Inpatient Operating Services (BHF Page 4, Line 25)	116,509,740	
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)	14,626,408	6,565,655
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**131,136,148**	**62,034,530**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	68.00%	32.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	101,424,310	91,080,307
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	40,331,792	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	5,489,169	
	F. Coronary Care Unit		
	G. Burn ICU	1,122,200	
	H. SICU	1,709,407	
	I. Trauma ICU	3,932,107	
	J. Neuro ICU	2,320,422	
	K. Neonatal ICU	18,876,808	
	L. Peds ICU	1,412,300	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	900,800	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	177,519,315	91,080,307
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		75,428,944
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)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

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)	131,136,148	62,034,530
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	131,136,148	62,034,530
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)**	**131,136,148**	**62,034,530**

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)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	75,428,944
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 Charge

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

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

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient Amount (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)**					

Hospital Statement of Cost

BHF Supplement No. 1

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

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

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)	

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

Part II - Routine Services Questionnaire

		Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1.	Gross Routine Revenues				
	(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)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Cost 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)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	15,523,973	178,344,390	0.087045	28,311,806	10,190,352	2,464,401	887,019
2.	Recovery Room							
3.	Delivery and Labor Room	1,398,091	3,935,526	0.355249	1,859,207	38,781	660,481	13,777
4.	Anesthesiology	6,374,818	57,724,435	0.110435	11,009,688	3,077,044	1,215,855	339,813
5.	Radiology - Diagnostic	4,047,314	161,303,914	0.025091	10,093,071	17,260,449	253,245	433,082
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,632,430	144,097,896	0.011329	11,689,866	13,208,052	132,434	149,634
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,001,812	6,385,889	0.313474	760,985	270,177	238,549	84,693
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,349,349	27,570,329	0.085213	3,391,404	1,671,283	288,992	142,415
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	198,592	132,784,581	0.001496	21,345,062	8,522,493	31,932	12,750
20.	Renal Dialysis							
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
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 Centers							
43.	Clinic	12,769,496	111,914,932	0.114100	246,130	16,091,314	28,083	1,836,019
44.	Emergency	16,093,934	61,143,486	0.263216	2,587,407	10,130,284	681,047	2,666,453
45.	Observation							
46.	**Ancillary Total**						**5,995,019**	**6,565,655**

* 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)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	21,575,087	83,741	257.64	20,993		5,408,637	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,350,255	7,440	450.30	2,057		926,267	
52.	Coronary Care Unit							
53.	Burn ICU	629,539	1,423	442.40	397		175,633	
54.	SICU	1,040,625	2,649	392.84	569		223,526	
55.	Trauma ICU							
56.	Neuro ICU	168,803	2,480	68.07	793		53,980	
57.	Neonatal ICU	1,793,290	9,096	197.15	6,035		1,189,800	
58.	Peds ICU	401,157	868	462.16	582		268,977	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	575,918	1,845	312.15	1,232		384,569	
67.	**Routine Total (lines 47-66)**						**8,631,389**	
68.	**Ancillary Total (from line 46)**						**5,995,019**	**6,565,655**
69.	**Total (Lines 67-68)**						**14,626,408**	**6,565,655**

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2014 To: 11/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	32,764		32,764
Newborn Days	1,232		1,232
Total Inpatient Revenue	177,519,315		177,519,315
Ancillary Revenue	101,424,310		101,424,310
Routine Revenue	76,095,005		76,095,005
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	N/A		N/A
Total Outpatient Revenue	91,080,307		91,080,307
Outpatient Received and Receivable			

Notes: