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: 12/01/2017	To: 11/30/2018	

Type of Contrc

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

Type of Hospita

XXXX 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 XXXX	Medicaid Hospital		Medicaid Sub II Rehab		
	Medicaid Sub I Psych		Medicaid Sub III Other		

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) John H. Stroger Jr. Hospital of Cc 0001 for the cost report beginning 12/01/2017 and ending 11/30/2018 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.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2017 To: 11/30/2018

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	113,150		58,913	52.07%		15,967	5.23
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	32	11,680		8,163	69.89%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,432	49.04%			
8.	SICU	14	5,110		2,665	52.15%			
9.	Trauma ICU	12	4,380		2,033	46.42%			
10.	Neuro ICU	10	3,650		2,024	55.45%			
11.	Neonatal ICU	52	18,980		7,036	37.07%			
12.	Peds ICU	10	3,650		1,251	34.27%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	9	3,285		1,763	53.67%			
22.	**Total**	**457**	**166,805**		**85,280**	**51.13%**		**15,967**	**5.23**
23.	Observation Bed Days				18,487				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,151			2,558	5.01
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,235				
6.	Coronary Care Unit								
7.	Burn ICU				205				
8.	SICU				416				
9.	Trauma ICU				319				
10.	Neuro ICU				321				
11.	Neonatal ICU				2,057				
12.	Peds ICU				121				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				622				
22.	**Total**				**13,447**	**15.77%**		**2,558**	**5.01**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	26,089	119,190

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: 12/01/2017 To: 11/30/2018

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	92,719,220	169,963,448	0.545524	10,383,722	205,211	5,664,570	111,948
2.	Recovery Room	9,100,043	18,714,165	0.486265	537,100	721,450	261,173	350,816
3.	Delivery and Labor Room	9,311,790	2,547,231	3.655652				
4.	Anesthesiology	12,914,714	60,762,623	0.212544	4,107,640	1,672,536	873,054	355,487
5.	Radiology - Diagnostic	62,249,705	178,470,306	0.348796	4,441,770	6,528,202	1,549,272	2,277,011
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	69,514,356	128,813,494	0.539651	6,410,926	2,809,660	3,459,663	1,516,236
9.	Blood							
10.	Blood - Administration	9,312,099	7,874,753	1.182526	568,052	59,234	671,736	70,046
11.	Intravenous Therapy				523	316,721		
12.	Respiratory Therapy	12,511,092	8,451,197	1.480393	826,373	82,572	1,223,357	122,239
13.	Physical Therapy	5,465,450	7,261,908	0.752619	479,653	19,890	360,996	14,970
14.	Occupational Therapy	1,719,915	2,083,565	0.825467	214,692	5,371	177,221	4,434
15.	Speech Pathology	1,114,614	1,739,211	0.640873	113,224	10,363	72,562	6,641
16.	EKG	17,663,014	36,459,312	0.484458	787,590	511,534	381,554	247,817
17.	EEG							
18.	Med. / Surg. Supplies	7,849,240	11,444,679	0.685842	1,530,166	463,303	1,049,452	317,753
19.	Drugs Charged to Patients	177,813,136	172,404,824	1.031370	9,794,792	2,081,931	10,102,055	2,147,241
20.	Renal Dialysis	6,165,497	8,412,282	0.732916	338,514		248,102	
21.	Ambulance							
22.	Implants	6,073,729	11,996,622	0.506287				
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	203,649,477	189,831,536	1.072791	715,782	4,552,744	767,884	4,884,143
44.	Emergency	61,204,833	69,696,222	0.878166	13,824	5,041,149	12,140	4,426,966
45.	Observation	32,178,472	47,751,061	0.673880	2,011,250	2,677,917	1,355,341	1,804,595
46.	**Total**				**43,275,593**	**27,759,788**	**28,230,132**	**18,658,343**

* 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: 12/01/2017 To: 11/30/2018

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)	133,726,008			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	77,400			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,727.73			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,151			
3.	Program general inpatient routine cost (Line 1c X Line 2)	14,082,727			
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)	14,082,727			

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	20,504,923	8,163	2,511.93	1,235	3,102,234
9.	Coronary Care Unit					
10.	Burn ICU	10,289,879	1,432	7,185.67	205	1,473,062
11.	SICU	7,798,881	2,665	2,926.41	416	1,217,387
12.	Trauma ICU	13,621,841	2,033	6,700.36	319	2,137,415
13.	Neuro ICU	5,665,928	2,024	2,799.37	321	898,598
14.	Neonatal ICU	10,548,225	7,036	1,499.18	2,057	3,083,813
15.	Peds ICU	1,479,786	1,251	1,182.88	121	143,128
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,459,311	1,763	3,096.60	622	1,926,085
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					28,230,132
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**56,294,581**

Hospital Statement of Cost

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: 12/01/2017 To: 11/30/2018

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: 12/01/2017 To: 11/30/2018

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	16,011,061	169,963,448	0.094203	10,383,722	205,211	978,178	19,331
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,812,191	60,762,623	0.062739	4,107,640	1,672,536	257,709	104,933
5.	Radiology - Diagnostic	5,275,194	178,470,306	0.029558	4,441,770	6,528,202	131,290	192,961
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,950,807	128,813,494	0.015144	6,410,926	2,809,660	97,087	42,549
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,797,685	8,451,197	0.331040	826,373	82,572	273,563	27,335
13.	Physical Therapy							
14.	Occupational Therapy	209,460	2,083,565	0.100530	214,692	5,371	21,583	540
15.	Speech Pathology							
16.	EKG	1,675,296	36,459,312	0.045950	787,590	511,534	36,190	23,505
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,287,503	8,412,282	0.153050	338,514		51,810	
21.	Ambulance							
22.	Implants							
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	10,621,855	189,831,536	0.055954	715,782	4,552,744	40,051	254,744
44.	Emergency	3,639,022	69,696,222	0.052213	13,824	5,041,149	722	263,214
45.	Observation							
46.	**Ancillary Total**						**1,888,183**	**929,112**

* 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: 12/01/2017 To: 11/30/2018

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	14,916,372	77,400	192.72	8,151		1,570,861	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU	253,117	1,432	176.76	205		36,236	
54.	SICU	274,203	2,665	102.89	416		42,802	
55.	Trauma ICU	1,005,541	2,033	494.61	319		157,781	
56.	Neuro ICU							
57.	Neonatal ICU	3,399,131	7,036	483.11	2,057		993,757	
58.	Peds ICU	627,473	1,251	501.58	121		60,691	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**2,862,128**	
68.	**Ancillary Total (from line 46)**						**1,888,183**	**929,112**
69.	**Total (Lines 67-68)**						**4,750,311**	**929,112**

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: 12/01/2017 To: 11/30/2018

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		18,658,343
2.	Inpatient Operating Services (BHF Page 4, Line 25)	56,294,581	
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)	4,750,311	929,112
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)	4,204,963	1,477,908
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**65,249,855**	**21,065,363**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	76.00%	24.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	43,275,593	27,759,788
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	15,420,845	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,146,494	
	F. Coronary Care Unit		
	G. Burn ICU	724,082	
	H. SICU	1,321,560	
	I. Trauma ICU	1,288,561	
	J. Neuro ICU	1,034,085	
	K. Neonatal ICU	6,720,125	
	L. Peds ICU	410,271	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	664,112	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	75,005,728	27,759,788
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		16,450,298
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: 12/01/2017 To: 11/30/2018

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)	65,249,855	21,065,363
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	65,249,855	21,065,363
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)**	**65,249,855**	**21,065,363**

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: 12/01/2017 To: 11/30/2018

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)	16,450,298
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: 12/01/2017 To: 11/30/2018

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

	Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psych**	**Sub II Rehab**	**Sub III 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)**				

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: 12/01/2017 To: 11/30/2018

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	11,793,046	169,963,448	0.069386	10,383,722	205,211	720,485	14,239
2.	Recovery Room							
3.	Delivery and Labor Room	940,196	2,547,231	0.369105				
4.	Anesthesiology	4,603,569	60,762,623	0.075763	4,107,640	1,672,536	311,207	126,716
5.	Radiology - Diagnostic	2,960,807	178,470,306	0.016590	4,441,770	6,528,202	73,689	108,303
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,518,779	128,813,494	0.011791	6,410,926	2,809,660	75,591	33,129
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,292,955	8,451,197	0.152991	826,373	82,572	126,428	12,633
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,886,297	36,459,312	0.051737	787,590	511,534	40,748	26,465
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	150,550	172,404,824	0.000873	9,794,792	2,081,931	8,551	1,818
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants							
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	11,618,881	189,831,536	0.061206	715,782	4,552,744	43,810	278,655
44.	Emergency	12,110,381	69,696,222	0.173760	13,824	5,041,149	2,402	875,950
45.	Observation							
46.	**Ancillary Total**						**1,402,911**	**1,477,908**

* 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: 12/01/2017 To: 11/30/2018

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	15,784,082	77,400	203.93	8,151		1,662,233	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,485,543	8,163	304.49	1,235		376,045	
52.	Coronary Care Unit							
53.	Burn ICU	498,880	1,432	348.38	205		71,418	
54.	SICU	724,705	2,665	271.93	416		113,123	
55.	Trauma ICU							
56.	Neuro ICU	110,698	2,024	54.69	321		17,555	
57.	Neonatal ICU	1,328,378	7,036	188.80	2,057		388,362	
58.	Peds ICU	295,195	1,251	235.97	121		28,552	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	410,321	1,763	232.74	622		144,764	
67.	**Routine Total (lines 47-66)**						**2,802,052**	
68.	**Ancillary Total (from line 46)**						**1,402,911**	**1,477,908**
69.	**Total (Lines 67-68)**						**4,204,963**	**1,477,908**

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: 12/01/2017 To: 11/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,825		12,825
Newborn Days	622		622
Total Inpatient Revenue	75,005,727	1	75,005,728
Ancillary Revenue	43,275,593		43,275,593
Routine Revenue	31,730,134	1	31,730,135
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	26,089		26,089
Total Outpatient Revenue	27,759,788		27,759,788
Outpatient Received and Receivable			

Notes:

See attached program routine charges distribution.

BHF Page 2 -See attached adustment to discharges

Adjustmens due to rounding