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: 12/01/2018	To: 11/30/2019

Type of Control

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 Hospital

[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 12/01/2018 and ending 11/30/2019 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: 12/01/2018	To:	11/30/2019

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	320	116,800		63,089	54.01%		13,238	6.52
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	32	11,680		8,255	70.68%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,328	45.48%			
8.	SICU	14	5,110		2,838	55.54%			
9.	Trauma ICU	12	4,380		2,175	49.66%			
10.	Neuro ICU	10	3,650		1,842	50.47%			
11.	Neonatal ICU	52	18,980		6,753	35.58%			
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	9	3,285		1,936	58.93%			
22.	**Total**	**457**	**166,805**		**88,216**	**52.89%**		**13,238**	**6.52**
23.	Observation Bed Days				20,907				

Line No.	**Part II-Program**	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,955			3,371	3.60
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,270				
6.	Coronary Care Unit								
7.	Burn ICU				159				
8.	SICU				375				
9.	Trauma ICU				433				
10.	Neuro ICU				370				
11.	Neonatal ICU				1,576				
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				646				
22.	**Total**				**12,784**	**14.49%**		**3,371**	**3.60**

Line No.	**Part III - Outpatient Statistics - Occasions of Service**	**Program**	**Total Hospital**
1.	Total Outpatient Occasions of Service	23,869	119,962

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: 12/01/2018	To:	11/30/2019

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	101,833,427	187,032,664	0.544469	9,877,267	272,975	5,377,866	148,626
2.	Recovery Room	7,862,839	15,185,200	0.517796	476,200	836,000	246,574	432,877
3.	Delivery and Labor Room	7,817,213	2,283,603	3.423193				
4.	Anesthesiology	13,202,771	63,486,319	0.207962	4,191,520	2,258,048	871,677	469,588
5.	Radiology - Diagnostic	58,626,962	184,344,206	0.318030	4,547,999	7,030,530	1,446,400	2,235,919
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	64,168,168	153,042,238	0.419284	6,646,895	3,551,860	2,786,937	1,489,238
9.	Blood							
10.	Blood - Administration	6,944,988	6,973,808	0.995867	537,408	59,094	535,187	58,850
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,092,251	10,923,080	1.381685	761,488	487,174	1,052,137	673,121
13.	Physical Therapy	6,431,419	8,501,164	0.756534	470,996	25,137	356,324	19,017
14.	Occupational Therapy	2,640,476	3,425,858	0.770749	241,644	5,178	186,247	3,991
15.	Speech Pathology	1,398,782	1,605,655	0.871160	65,670	11,693	57,209	10,186
16.	EKG	19,772,974	38,178,800	0.517905	884,270	535,706	457,968	277,445
17.	EEG							
18.	Med. / Surg. Supplies	12,330,539	32,383,642	0.380764	2,272,165	938,373	865,159	357,299
19.	Drugs Charged to Patients	193,012,447	204,119,398	0.945586	10,585,920	1,670,356	10,009,898	1,579,465
20.	Renal Dialysis	5,899,523	10,136,688	0.581997	513,792		299,025	
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	176,892,239	124,669,914	1.418885	820,555	5,895,627	1,164,273	8,365,217
44.	Emergency	62,508,491	65,646,414	0.952200	17,664	5,883,032	16,820	5,601,823
45.	Observation	35,777,940	48,951,857	0.730880	1,752,793	2,920,701	1,281,081	2,134,682
46.	**Total**				**44,664,246**	**32,381,484**	**27,010,782**	**23,857,344**

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:			
14-0124			0001	
Program:	Period Covered by Statement:			
Medicaid Hospital	From:	12/01/2018	To:	11/30/2019

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)	142,179,051			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	83,996			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,692.69			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,955			
3.	Program general inpatient routine cost (Line 1c X Line 2)	13,465,349			
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)	13,465,349			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	19,944,060	8,255	2,416.00	1,270	3,068,320
9.	Coronary Care Unit					
10.	Burn ICU	9,477,121	1,328	7,136.39	159	1,134,686
11.	SICU	8,860,334	2,838	3,122.03	375	1,170,761
12.	Trauma ICU	15,191,248	2,175	6,984.48	433	3,024,280
13.	Neuro ICU	5,616,499	1,842	3,049.13	370	1,128,178
14.	Neonatal ICU	14,322,273	6,753	2,120.88	1,576	3,342,507
15.	Peds ICU					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,836,617	1,936	3,014.78	646	1,947,548
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					27,010,782
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**55,292,411**

Hospital Statement of Cost

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

Preliminary

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2018 To: 11/30/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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: 12/01/2018 To: 11/30/2019

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	10,649,099	187,032,664	0.056937	9,877,267	272,975	562,382	15,542
2.	Recovery Room	351,634	15,185,200	0.023156	476,200	836,000	11,027	19,358
3.	Delivery and Labor Room							
4.	Anesthesiology	5,170,222	63,486,319	0.081438	4,191,520	2,258,048	341,349	183,891
5.	Radiology - Diagnostic	4,021,979	184,344,206	0.021818	4,547,999	7,030,530	99,228	153,392
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,664,510	153,042,238	0.017410	6,646,895	3,551,860	115,722	61,838
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,661,479	10,923,080	0.243656	761,488	487,174	185,541	118,703
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,225,466	38,178,800	0.058291	884,270	535,706	51,545	31,227
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,496,458	10,136,688	0.147628	513,792		75,850	
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	17,183,499	124,669,914	0.137832	820,555	5,895,627	113,099	812,606
44.	Emergency	4,125,428	65,646,414	0.062843	17,664	5,883,032	1,110	369,707
45.	Observation							
46.	**Ancillary Total**						**1,556,853**	**1,766,264**

* 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: Medicaid Hospital	Period Covered by Statement: From: 12/01/2018 To: 11/30/2019

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	12,542,821	83,996	149.33	7,955		1,187,920	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	247,976	8,255	30.04	1,270		38,151	
52.	Coronary Care Unit							
53.	Burn ICU	477,304	1,328	359.42	159		57,148	
54.	SICU	307,052	2,838	108.19	375		40,571	
55.	Trauma ICU	1,258,259	2,175	578.51	433		250,495	
56.	Neuro ICU							
57.	Neonatal ICU	84,693	6,753	12.54	1,576		19,763	
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)**						**1,594,048**	
68.	**Ancillary Total (from line 46)**						**1,556,853**	**1,766,264**
69.	**Total (Lines 67-68)**						**3,150,901**	**1,766,264**

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	Period Covered by Statement:
Medicaid Hospital	From: 12/01/2018 To: 11/30/2019

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		23,857,344
2.	Inpatient Operating Services (BHF Page 4, Line 25)	55,292,411	
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)	3,150,901	1,766,264
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)	3,190,530	1,712,919
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**61,633,842**	**27,336,527**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	69.00%	31.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	44,664,246	32,381,484
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	14,214,724	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,239,006	
	F. Coronary Care Unit		
	G. Burn ICU	1,197,796	
	H. SICU	1,236,011	
	I. Trauma ICU	3,192,431	
	J. Neuro ICU	1,190,929	
	K. Neonatal ICU	3,528,602	
	L. Peds ICU		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,055,839	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	74,519,584	32,381,484
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		17,930,699
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: 12/01/2018	To: 11/30/2019

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)	61,633,842	27,336,527
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	61,633,842	27,336,527
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)**	**61,633,842**	**27,336,527**

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.

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:	12/01/2018	To:	11/30/2019

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

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)	17,930,699
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

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(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		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	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: 12/01/2018**	**To:**	**11/30/2019**

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

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	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: Medicaid Hospital	Period Covered by Statement: From: 12/01/2018 To: 11/30/2019

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	9,857,605	187,032,664	0.052705	9,877,267	272,975	520,581	14,387
2.	Recovery Room							
3.	Delivery and Labor Room	785,894	2,283,603	0.344147				
4.	Anesthesiology	3,848,043	63,486,319	0.060612	4,191,520	2,258,048	254,056	136,865
5.	Radiology - Diagnostic	2,474,888	184,344,206	0.013425	4,547,999	7,030,530	61,057	94,385
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,269,521	153,042,238	0.008295	6,646,895	3,551,860	55,136	29,463
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,080,759	10,923,080	0.098943	761,488	487,174	75,344	48,202
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,576,723	38,178,800	0.041298	884,270	535,706	36,519	22,124
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	125,841	204,119,398	0.000617	10,585,920	1,670,356	6,532	1,031
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	9,712,023	124,669,914	0.077902	820,555	5,895,627	63,923	459,281
44.	Emergency	10,122,860	65,646,414	0.154203	17,664	5,883,032	2,724	907,181
45.	Observation							
46.	**Ancillary Total**						**1,075,872**	**1,712,919**

* 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: 12/01/2018 To: 11/30/2019

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	13,440,393	83,996	160.01	7,955		1,272,880	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,077,623	8,255	251.68	1,270		319,634	
52.	Coronary Care Unit							
53.	Burn ICU	417,005	1,328	314.01	159		49,928	
54.	SICU	605,768	2,838	213.45	375		80,044	
55.	Trauma ICU							
56.	Neuro ICU	92,531	1,842	50.23	370		18,585	
57.	Neonatal ICU	1,110,369	6,753	164.43	1,576		259,142	
58.	Peds ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	342,981	1,936	177.16	646		114,445	
67.	**Routine Total (lines 47-66)**						**2,114,658**	
68.	**Ancillary Total (from line 46)**						**1,075,872**	**1,712,919**
69.	**Total (Lines 67-68)**						**3,190,530**	**1,712,919**

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: 12/01/2018 To: 11/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,138		12,138
Newborn Days	646		646
Total Inpatient Revenue	74,519,585	(1)	74,519,584
Ancillary Revenue	44,664,247	(1)	44,664,246
Routine Revenue	29,855,338		29,855,338
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	23,869		23,869
Total Outpatient Revenue	32,381,483	1	32,381,484
Outpatient Received and Receivable			

Notes:

BHF Page 2, Part I, Line 1, Col 7 - adjusted to agree with as filed Medicare Report W/S S-3, Col 7. See attached worksheet to see how total was determined.

BHF Page 2, Part II, Col 4 - Adjusted Program Days due to Provider reporting CCU and Ped ICU days despite not reporting any Beds or Bed Days Available and despite not reporting any days on as filed Medicare Report. See attached worksheet to see how the program days were reallocated.

BHF Page 3 - Blood was reclassified to Blood Administration

BHF Page 7 - See attached program routine charges distribution.

Adjustments due to rounding