

Hospital Statement of Cost

BHF Page 1

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

General Information Preliminary-Revised

Name of Hospital: Johh H. Stronger, Jr. Hospital fo 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: 12/01/2012	To: 11/30/2013	

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	☐ 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)) Johh H. Stronger, Jr. Hospital 0001 for the cost report beginning 12/01/2012 and ending 11/30/2013 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)

Title	Date
Firm	
Telephone Number	
Email Address	

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

BHF Page 2

Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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	322	117,530	81,373	81,373	69.24%		22,601	4.74
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	34	12,410		7,508	60.50%			
6.	Coronary Care Unit								
7.	Burn ICU	6	2,190		1,207	55.11%			
8.	SICU	14	5,110		2,430	47.55%			
9.	Trauma ICU	12	4,380		2,357	53.81%			
10.	Neuro ICU	10	3,650		2,222	60.88%			
11.	Neonatal ICU	52	18,980		9,073	47.80%			
12.	Peds ICU	10	3,650		964	26.41%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,490		1,800	18.97%			
22.	Total	486	177,390	81,373	108,934	61.41%		22,601	4.74
23.	Observation Bed Days				5,017				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				26,461			7,619	5.27
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				3,234				
6.	Coronary Care Unit								
7.	Burn ICU				344				
8.	SICU				680				
9.	Trauma ICU				1,319				
10.	Neuro ICU				120				
11.	Neonatal ICU				7,413				
12.	Peds ICU				582				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,237				
22.	Total				41,390	38.00%		7,619	5.27

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	88,841	754,013

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

BHF Page 3

Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	94,835,305	171,572,065	0.552743	29,863,425	7,345,077	16,506,799	4,059,940
2.	Recovery Room	5,932,730	11,249,309	0.527386	976,716	839,087	515,106	442,523
3.	Delivery and Labor Room	7,783,168	2,657,498	2.928758	1,511,017	34,066	4,425,403	99,771
4.	Anesthesiology	5,147,462	55,093,541	0.093431	11,159,443	2,254,824	1,042,638	210,670
5.	Radiology - Diagnostic	44,883,282	158,128,366	0.283841	12,981,457	17,658,344	3,684,670	5,012,162
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	51,722,532	132,646,348	0.389928	14,839,422	11,753,605	5,786,306	4,583,060
9.	Blood	7,017,255	9,174,876	0.764834	2,239,791	514,027	1,713,068	393,145
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,154,409	1,759,533	5.771082	5,669	342,119	32,716	1,974,397
13.	Physical Therapy	2,794,715	1,927,141	1.450187	282,754	111,652	410,046	161,916
14.	Occupational Therapy	1,251,612	1,107,628	1.129993	124,043	90,738	140,168	102,533
15.	Speech Pathology	1,452,356	695,912	2.086982	1,870	110,556	3,903	230,728
16.	EKG	12,606,140	22,439,632	0.561780	2,557,186	1,172,810	1,436,576	658,861
17.	EEG							
18.	Med. / Surg. Supplies	6,728,680	18,920,020	0.355638	2,940,026	1,696,096	1,045,585	603,196
19.	Drugs Charged to Patients	64,624,946	98,795,751	0.654127	23,732,474	8,924,784	15,524,052	5,837,942
20.	Renal Dialysis	5,576,138	7,585,867	0.735069	11,029	1,769,585	8,107	1,300,767
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	118,933,284	112,499,029	1.057194	7,744	17,007,782	8,187	17,980,525
44.	Emergency	52,534,384	78,282,063	0.671091	43,039	11,687,987	28,883	7,843,703
45.	Observation	7,515,366	18,022,331	0.417003		3,575,649		1,491,056
46.	Total				103,277,105	86,888,788	52,312,213	52,986,895

* 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

Preliminary-Revised

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2012 To: 11/30/2013

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)	124,554,888			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	86,390			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,441.77			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	26,461			
3.	Program general inpatient routine cost (Line 1c X Line 2)	38,150,676			
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)	38,150,676			

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	18,136,867	7,508	2,415.67	3,234	7,812,277
9.	Coronary Care Unit					
10.	Burn ICU	3,991,686	1,207	3,307.11	344	1,137,646
11.	SICU	7,559,199	2,430	3,110.78	680	2,115,330
12.	Trauma ICU	10,731,023	2,357	4,552.83	1,319	6,005,183
13.	Neuro ICU	5,020,915	2,222	2,259.64	120	271,157
14.	Neonatal ICU	14,299,798	9,073	1,576.08	7,413	11,683,481
15.	Peds ICU	4,107,761	964	4,261.16	582	2,479,995
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,923,732	1,800	2,735.41	1,237	3,383,702
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					52,312,213
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					125,351,660

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**
Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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)	
		(1)	(2)	(3)	(4)	Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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	10,972,621	171,572,065	0.063953	29,863,425	7,345,077	1,909,856	469,740
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	4,216,410	55,093,541	0.076532	11,159,443	2,254,824	854,054	172,566
5.	Radiology - Diagnostic	7,297,662	158,128,366	0.046150	12,981,457	17,658,344	599,094	814,933
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	3,836,692	132,646,348	0.028924	14,839,422	11,753,605	429,215	339,961
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,069,100	1,759,533	1.175937	5,669	342,119	6,666	402,310
13.	Physical Therapy							
14.	Occupational Therapy	14,361	1,107,628	0.012966	124,043	90,738	1,608	1,177
15.	Speech Pathology							
16.	EKG	2,052,763	22,439,632	0.091479	2,557,186	1,172,810	233,929	107,287
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	18,857,098	112,499,029	0.167620	7,744	17,007,782	1,298	2,850,844
44.	Emergency	1,452,632	78,282,063	0.018556	43,039	11,687,987	799	216,882
45.	Observation							
46.	Ancillary Total						4,036,519	5,375,700

* 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

BHF Page 6(b)

Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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	23,601,124	86,390	273.19	26,461		7,228,881	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	154,381	7,508	20.56	3,234		66,491	
52.	Coronary Care Unit							
53.	Burn ICU	991,225	1,207	821.23	344		282,503	
54.	SICU	43,866	2,430	18.05	680		12,274	
55.	Trauma ICU	2,232,626	2,357	947.23	1,319		1,249,396	
56.	Neuro ICU	659,010	2,222	296.58	120		35,590	
57.	Neonatal ICU	2,907,360	9,073	320.44	7,413		2,375,422	
58.	Peds ICU	728,660	964	755.87	582		439,916	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						11,690,473	
68.	Ancillary Total (from line 46)						4,036,519	5,375,700
69.	Total (Lines 67-68)						15,726,992	5,375,700

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

BHF Page 7

Preliminary-Revised

Medicare Provider Number: 14-0124		Medicaid Provider Number: 0001	
Program: Medicaid Hospital		Period Covered by Statement: From: 12/01/2012 To: 11/30/2013	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		52,986,895
2.	Inpatient Operating Services (BHF Page 4, Line 25)	125,351,660	
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)	15,726,992	5,375,700
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)	13,535,520	4,755,267
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	154,614,172	63,117,862
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	71.00%	29.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	103,277,105	86,888,788
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	64,881,999	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	8,113,181	
	F. Coronary Care Unit		
	G. Burn ICU	862,116	
	H. SICU	1,703,913	
	I. Trauma ICU	3,312,036	
	J. Neuro ICU	301,886	
	K. Neonatal ICU	16,830,110	
	L. Peds ICU	1,438,278	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	989,454	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	201,710,078	86,888,788
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		70,866,832
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

BHF Page 8

Preliminary-Revised

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2012 To: 11/30/2013

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	154,614,172	63,117,862
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	154,614,172	63,117,862
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)	154,614,172	63,117,862

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(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

BHF Page 9

Preliminary-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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)	70,866,832
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)	(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary-Revised

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2012 To: 11/30/2013

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

1. 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-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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	10,146,974	171,572,065	0.059141	29,863,425	7,345,077	1,766,153	434,395
2.	Recovery Room							
3.	Delivery and Labor Room	621,177	2,657,498	0.233745	1,511,017	34,066	353,193	7,963
4.	Anesthesiology	4,177,216	55,093,541	0.075820	11,159,443	2,254,824	846,109	170,961
5.	Radiology - Diagnostic	2,926,794	158,128,366	0.018509	12,981,457	17,658,344	240,274	326,838
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	304,942	132,646,348	0.002299	14,839,422	11,753,605	34,116	27,022
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,548,910	1,759,533	0.880296	5,669	342,119	4,990	301,166
13.	Physical Therapy							
14.	Occupational Therapy	48,403	1,107,628	0.043700	124,043	90,738	5,421	3,965
15.	Speech Pathology							
16.	EKG	2,274,961	22,439,632	0.101381	2,557,186	1,172,810	259,250	118,901
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 Centers							
43.	Clinic	10,492,251	112,499,029	0.093265	7,744	17,007,782	722	1,586,231
44.	Emergency	11,907,246	78,282,063	0.152107	43,039	11,687,987	6,547	1,777,825
45.	Observation							
46.	Ancillary Total						3,516,775	4,755,267

* 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-Revised

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2012 To: 11/30/2013

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	21,891,263	86,390	253.40	26,461		6,705,217	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,744,475	7,508	365.54	3,234		1,182,156	
52.	Coronary Care Unit							
53.	Burn ICU	587,295	1,207	486.57	344		167,380	
54.	SICU	758,321	2,430	312.07	680		212,208	
55.	Trauma ICU							
56.	Neuro ICU	393,681	2,222	177.17	120		21,260	
57.	Neonatal ICU	1,477,918	9,073	162.89	7,413		1,207,504	
58.	Peds ICU	322,690	964	334.74	582		194,819	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	477,581	1,800	265.32	1,237		328,201	
67.	Routine Total (lines 47-66)						10,018,745	
68.	Ancillary Total (from line 46)						3,516,775	4,755,267
69.	Total (Lines 67-68)						13,535,520	4,755,267

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary-Revised

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2012 To: 11/30/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	40,153		40,153
Newborn Days	1,237		1,237
Total Inpatient Revenue	201,710,078		201,710,078
Ancillary Revenue	103,277,105		103,277,105
Routine Revenue	98,432,973		98,432,973
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	88,841		88,841
Total Outpatient Revenue	86,888,788		86,888,788
Outpatient Received and Receivable			

Notes:

This report was revised due to Revised Medicare report submitted on 02/27/2014---DW.