

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

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

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				8,947				

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

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	88,756,040	171,572,065	0.517311	29,863,425	7,345,077	15,448,678	3,799,689
2.	Recovery Room	5,555,098	11,249,309	0.493817	976,716	839,087	482,319	414,355
3.	Delivery and Labor Room	7,352,064	2,657,498	2.766536	1,511,017	34,066	4,180,283	94,245
4.	Anesthesiology	4,560,420	55,093,541	0.082776	11,159,443	2,254,824	923,734	186,645
5.	Radiology - Diagnostic	41,287,945	158,128,366	0.261104	12,981,457	17,658,344	3,389,510	4,610,664
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	48,794,963	132,646,348	0.367858	14,839,422	11,753,605	5,458,800	4,323,658
9.	Blood	6,767,089	9,174,876	0.737567	2,239,791	514,027	1,651,996	379,129
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,392,739	1,759,533	5.338200	5,669	342,119	30,262	1,826,300
13.	Physical Therapy	2,632,960	1,927,141	1.366252	282,754	111,652	386,313	152,545
14.	Occupational Therapy	1,153,570	1,107,628	1.041478	124,043	90,738	129,188	94,502
15.	Speech Pathology	1,356,236	695,912	1.948861	1,870	110,556	3,644	215,458
16.	EKG	11,282,672	22,439,632	0.502801	2,557,186	1,172,810	1,285,756	589,690
17.	EEG							
18.	Med. / Surg. Supplies	6,419,025	18,920,020	0.339272	2,940,026	1,696,096	997,469	575,438
19.	Drugs Charged to Patients	63,408,789	98,795,751	0.641817	23,732,474	8,924,784	15,231,905	5,728,078
20.	Renal Dialysis	5,347,840	7,585,867	0.704974	11,029	1,769,585	7,775	1,247,511
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	118,776,943	112,499,029	1.055804	7,744	17,007,782	8,176	17,956,884
44.	Emergency	49,609,037	78,282,063	0.633722	43,039	11,687,987	27,275	7,406,934
45.	Observation	11,452,339	18,022,331	0.635453		3,575,649		2,272,157
46.	Total				103,277,105	86,888,788	49,643,083	51,873,882

* 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

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)	110,755,517			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	90,320			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,226.26			
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)	32,448,066			
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)	32,448,066			

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	17,135,676	7,508	2,282.32	3,234	7,381,023
9.	Coronary Care Unit					
10.	Burn ICU	3,768,710	1,207	3,122.38	344	1,074,099
11.	SICU	7,175,508	2,430	2,952.88	680	2,007,958
12.	Trauma ICU	9,949,836	2,357	4,221.40	1,319	5,568,027
13.	Neuro ICU	4,781,508	2,222	2,151.89	120	258,227
14.	Neonatal ICU	13,640,733	9,073	1,503.44	7,413	11,145,001
15.	Peds ICU	3,878,993	964	4,023.85	582	2,341,881
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,651,265	1,800	2,584.04	1,237	3,196,457
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					49,643,083
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					115,063,822

**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: 12/01/2012 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

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

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	90,320	261.31	26,461		6,914,524	
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)						11,376,116	
68.	Ancillary Total (from line 46)						4,036,519	5,375,700
69.	Total (Lines 67-68)						15,412,635	5,375,700

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

BHF Page 7

Preliminary

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)		51,873,882
2.	Inpatient Operating Services (BHF Page 4, Line 25)	115,063,822	
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)	15,412,635	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)	12,845,216	4,612,150
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	143,321,673	61,861,732
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	70.00%	30.00%

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)		83,415,461
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

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)	143,321,673	61,861,732
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	143,321,673	61,861,732
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)	143,321,673	61,861,732

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

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)	83,415,461
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

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

Medicare Provider Number:		Medicaid Provider Number:	
14-0124		0001	
Program:		Period Covered by Statement:	
Medicaid Hospital		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	9,841,574	171,572,065	0.057361	29,863,425	7,345,077	1,712,996	421,321
2.	Recovery Room							
3.	Delivery and Labor Room	602,482	2,657,498	0.226710	1,511,017	34,066	342,563	7,723
4.	Anesthesiology	4,051,492	55,093,541	0.073538	11,159,443	2,254,824	820,643	165,815
5.	Radiology - Diagnostic	2,838,705	158,128,366	0.017952	12,981,457	17,658,344	233,043	317,003
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	295,764	132,646,348	0.002230	14,839,422	11,753,605	33,092	26,211
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,502,292	1,759,533	0.853802	5,669	342,119	4,840	292,102
13.	Physical Therapy							
14.	Occupational Therapy	46,946	1,107,628	0.042384	124,043	90,738	5,257	3,846
15.	Speech Pathology							
16.	EKG	2,206,490	22,439,632	0.098330	2,557,186	1,172,810	251,448	115,322
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	10,176,460	112,499,029	0.090458	7,744	17,007,782	701	1,538,490
44.	Emergency	11,548,866	78,282,063	0.147529	43,039	11,687,987	6,350	1,724,317
45.	Observation							
46.	Ancillary Total						3,410,933	4,612,150

* 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:	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	21,232,388	90,320	235.08	26,461		6,220,452	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,661,873	7,508	354.54	3,234		1,146,582	
52.	Coronary Care Unit							
53.	Burn ICU	569,619	1,207	471.93	344		162,344	
54.	SICU	735,496	2,430	302.67	680		205,816	
55.	Trauma ICU							
56.	Neuro ICU	381,832	2,222	171.84	120		20,621	
57.	Neonatal ICU	1,433,436	9,073	157.99	7,413		1,171,180	
58.	Peds ICU	312,978	964	324.67	582		188,958	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	463,207	1,800	257.34	1,237		318,330	
67.	Routine Total (lines 47-66)						9,434,283	
68.	Ancillary Total (from line 46)						3,410,933	4,612,150
69.	Total (Lines 67-68)						12,845,216	4,612,150

Preliminary

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			

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