

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: 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: 12/01/2013	To: 11/30/2014	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ Other (Specify) _____	☐ Corporation	☐ County XXXX XXXX	☐ 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)) John H. Stroger Jr. Hospital of 0001 for the cost report beginning 12/01/2013 and ending 11/30/2014 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: 12/01/2013 To: 11/30/2014

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	72,961	72,961	62.08%		20,608	4.82
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	34	12,410		6,919	55.75%			
6.	Coronary Care Unit								
7.	Burn ICU	6	2,190		1,201	54.84%			
8.	SICU	14	5,110		2,574	50.37%			
9.	Trauma ICU	12	4,380		2,720	62.10%			
10.	Neuro ICU	10	3,650		2,509	68.74%			
11.	Neonatal ICU	52	18,980		9,482	49.96%			
12.	Peds ICU	10	3,650		926	25.37%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,490		2,070	21.81%			
22.	Total	486	177,390	72,961	101,362	57.14%		20,608	4.82
23.	Observation Bed Days				11,730				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				24,361			7,263	5.42
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				3,270				
6.	Coronary Care Unit								
7.	Burn ICU				387				
8.	SICU				711				
9.	Trauma ICU				1,666				
10.	Neuro ICU				126				
11.	Neonatal ICU				8,328				
12.	Peds ICU				495				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,808				
22.	Total				41,152	40.60%		7,263	5.42

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	116,260	586,662

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

BHF Page 3

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
14-0124		0001	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 12/01/2013	To: 11/30/2014

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	69,569,762	178,840,763	0.389004	30,579,750	10,824,668	11,895,645	4,210,839
2.	Recovery Room	5,265,152	12,860,429	0.409407	1,469,290	1,219,090	601,538	499,104
3.	Delivery and Labor Room	7,380,211	3,523,774	2.094405	2,229,697	10,103	4,669,889	21,160
4.	Anesthesiology	4,333,801	55,941,272	0.077471	11,903,864	3,105,366	922,204	240,576
5.	Radiology - Diagnostic	43,266,757	152,278,395	0.284129	12,856,583	18,047,743	3,652,928	5,127,887
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	48,816,012	139,486,928	0.349968	14,895,984	14,374,337	5,213,118	5,030,558
9.	Blood							
10.	Blood - Administration	6,111,849	9,498,219	0.643473	2,755,918	608,212	1,773,359	391,368
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,211,102	824,782	12.380365	4,515	182,546	55,897	2,259,986
13.	Physical Therapy	2,903,913	2,459,140	1.180865	268,188	283,384	316,694	334,638
14.	Occupational Therapy	1,298,685	1,537,938	0.844433	147,168	216,922	124,274	183,176
15.	Speech Pathology	1,552,865	1,181,702	1.314092	4,447	210,507	5,844	276,626
16.	EKG	12,159,900	26,598,176	0.457170	3,639,424	1,810,993	1,663,835	827,932
17.	EEG							
18.	Med. / Surg. Supplies	11,122,541	30,117,553	0.369304	4,946,079	1,543,350	1,826,607	569,965
19.	Drugs Charged to Patients	63,360,692	103,262,142	0.613591	23,694,004	9,037,492	14,538,428	5,545,324
20.	Renal Dialysis	5,247,000	5,292,072	0.991483	12,264	1,248,159	12,160	1,237,528
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	116,460,360	110,773,325	1.051339	132,330	18,219,511	139,124	19,154,882
44.	Emergency	51,357,480	74,157,779	0.692543	3,483,300	10,182,861	2,412,335	7,052,069
45.	Observation	16,681,585	22,441,793	0.743327	1,755,946	3,860,989	1,305,242	2,869,977
46.	Total				114,778,751	94,986,233	51,129,121	55,833,595

* 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: 12/01/2013 To: 11/30/2014

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	115,963,856			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	84,691			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,369.26			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	24,361			
3.	Program general inpatient routine cost (Line 1c X Line 2)	33,356,543			
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)	33,356,543			

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	16,885,642	6,919	2,440.47	3,270	7,980,337
9.	Coronary Care Unit					
10.	Burn ICU	4,268,038	1,201	3,553.74	387	1,375,297
11.	SICU	7,137,581	2,574	2,772.95	711	1,971,567
12.	Trauma ICU	10,591,200	2,720	3,893.82	1,666	6,487,104
13.	Neuro ICU	5,071,905	2,509	2,021.48	126	254,706
14.	Neonatal ICU	13,003,622	9,482	1,371.40	8,328	11,421,019
15.	Peds ICU	4,077,005	926	4,402.81	495	2,179,391
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,761,566	2,070	2,300.27	1,808	4,158,888
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					51,129,121
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					120,313,973

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: 12/01/2013 To: 11/30/2014

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: 12/01/2013 To: 11/30/2014

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	10,436,129	178,840,763	0.058354	30,579,750	10,824,668	1,784,451	631,663
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	2,639,492	55,941,272	0.047183	11,903,864	3,105,366	561,660	146,520
5.	Radiology - Diagnostic	7,686,294	152,278,395	0.050475	12,856,583	18,047,743	648,936	910,960
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	3,826,061	139,486,928	0.027430	14,895,984	14,374,337	408,597	394,288
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,686,066	824,782	2.044257	4,515	182,546	9,230	373,171
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,057,739	26,598,176	0.077364	3,639,424	1,810,993	281,560	140,106
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	18,312,667	110,773,325	0.165317	132,330	18,219,511	21,876	3,011,995
44.	Emergency	1,435,412	74,157,779	0.019356	3,483,300	10,182,861	67,423	197,099
45.	Observation							
46.	Ancillary Total						3,783,733	5,805,802

* 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: 12/01/2013 To: 11/30/2014

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	23,405,295	84,691	276.36	24,361		6,732,406	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	282,036	6,919	40.76	3,270		133,285	
52.	Coronary Care Unit							
53.	Burn ICU	929,195	1,201	773.68	387		299,414	
54.	SICU							
55.	Trauma ICU	2,030,271	2,720	746.42	1,666		1,243,536	
56.	Neuro ICU	562,306	2,509	224.12	126		28,239	
57.	Neonatal ICU	2,808,459	9,482	296.19	8,328		2,466,670	
58.	Peds ICU	665,689	926	718.89	495		355,851	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						11,259,401	
68.	Ancillary Total (from line 46)						3,783,733	5,805,802
69.	Total (Lines 67-68)						15,043,134	5,805,802

**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: 12/01/2013 To: 11/30/2014

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			55,833,595
2. Inpatient Operating Services (BHF Page 4, Line 25)		120,313,973	
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)		15,043,134	5,805,802
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)		11,747,556	4,481,195
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		147,104,663	66,120,592
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)		114,778,751	94,986,233
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		53,850,644	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		8,267,519	
F. Coronary Care Unit			
G. Burn ICU		1,288,385	
H. SICU		2,747,389	
I. Trauma ICU		4,263,924	
J. Neuro ICU		2,792,945	
K. Neonatal ICU		20,764,599	
L. Peds ICU		1,583,223	
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		1,144,800	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		211,482,179	94,986,233
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			93,243,157
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: 12/01/2013 To: 11/30/2014

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)	147,104,663	66,120,592
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	147,104,663	66,120,592
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)	147,104,663	66,120,592

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: 12/01/2013 To: 11/30/2014

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)	93,243,157
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: 12/01/2013 To: 11/30/2014

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:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2013 To: 11/30/2014

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	10,427,916	178,840,763	0.058308	30,579,750	10,824,668	1,783,044	631,165
2.	Recovery Room							
3.	Delivery and Labor Room	866,152	3,523,774	0.245802	2,229,697	10,103	548,064	2,483
4.	Anesthesiology	4,382,589	55,941,272	0.078343	11,903,864	3,105,366	932,584	243,284
5.	Radiology - Diagnostic	2,800,329	152,278,395	0.018390	12,856,583	18,047,743	236,433	331,898
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	907,072	139,486,928	0.006503	14,895,984	14,374,337	96,869	93,476
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,406,302	824,782	1.705059	4,515	182,546	7,698	311,252
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,785,499	26,598,176	0.067129	3,639,424	1,810,993	244,311	121,570
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	147,314	103,262,142	0.001427	23,694,004	9,037,492	33,811	12,897
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	7,582,575	110,773,325	0.068451	132,330	18,219,511	9,058	1,247,144
44.	Emergency	10,822,117	74,157,779	0.145934	3,483,300	10,182,861	508,332	1,486,026
45.	Observation							
46.	Ancillary Total						4,400,204	4,481,195

* 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: 12/01/2013 To: 11/30/2014

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	15,182,879	84,691	179.27	24,361		4,367,196	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,367,935	6,919	342.24	3,270		1,119,125	
52.	Coronary Care Unit							
53.	Burn ICU	431,030	1,201	358.89	387		138,890	
54.	SICU	750,210	2,574	291.46	711		207,228	
55.	Trauma ICU							
56.	Neuro ICU	193,691	2,509	77.20	126		9,727	
57.	Neonatal ICU	1,186,696	9,482	125.15	8,328		1,042,249	
58.	Peds ICU	268,712	926	290.19	495		143,644	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	365,557	2,070	176.60	1,808		319,293	
67.	Routine Total (lines 47-66)						7,347,352	
68.	Ancillary Total (from line 46)						4,400,204	4,481,195
69.	Total (Lines 67-68)						11,747,556	4,481,195

Preliminary

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2013 To: 11/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	39,344		39,344
Newborn Days	1,808		1,808
Total Inpatient Revenue	211,482,179		211,482,179
Ancillary Revenue	114,778,751		114,778,751
Routine Revenue	96,703,428		96,703,428
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	116,260		116,260
Total Outpatient Revenue	94,986,233		94,986,233
Outpatient Received and Receivable			

Notes:

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