

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: 12/01/2019	To: 11/30/2020	

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 0001 for the cost report beginning 12/01/2019 and ending 11/30/2020 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: 12/01/2019 To: 11/30/2020

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	117,120		58,822	50.22%		15,808	5.18
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	37	13,542		8,667	64.00%			
6.	Coronary Care Unit								
7.	Burn ICU	6	2,196		1,352	61.57%			
8.	SICU	14	5,124		2,977	58.10%			
9.	Trauma ICU	12	4,392		2,519	57.35%			
10.	Neuro ICU	10	3,660		1,986	54.26%			
11.	Neonatal ICU	52	19,032		5,568	29.26%			
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,526				
22.	Total	451	165,066		83,417	50.54%		15,808	5.18
23.	Observation Bed Days				12,813				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,459			3,999	3.75
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,157				
6.	Coronary Care Unit								
7.	Burn ICU				148				
8.	SICU				445				
9.	Trauma ICU				396				
10.	Neuro ICU				429				
11.	Neonatal ICU				945				
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				729				
22.	Total				15,708	18.83%		3,999	3.75

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	20,226	87,251

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: 12/01/2019	To: 11/30/2020

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)		(4)	(5)	(6)	(7)
1.	Operating Room	79,606,295	149,665,768	0.531894	11,714,198	287,754	6,230,712	153,055
2.	Recovery Room	8,194,635	12,648,850	0.647856	605,700	1,149,800	392,406	744,905
3.	Delivery and Labor Room	7,647,014	1,740,822	4.392760				
4.	Anesthesiology	15,497,816	54,333,976	0.285233	4,765,016	2,959,332	1,359,140	844,099
5.	Radiology - Diagnostic	62,135,999	156,933,677	0.395938	5,785,417	8,464,995	2,290,666	3,351,613
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	50,905,697	134,806,135	0.377622	9,913,904	6,080,411	3,743,708	2,296,097
9.	Blood							
10.	Blood - Administration	7,287,279	12,276,730	0.593585	687,173	57,070	407,896	33,876
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,508,084	17,282,522	0.608018	2,193,198	504,363	1,333,504	306,662
13.	Physical Therapy	6,897,661	6,796,114	1.014942	653,659	57,376	663,426	58,233
14.	Occupational Therapy	2,794,104	2,833,426	0.986122	287,485	38,277	283,495	37,746
15.	Speech Pathology	1,412,233	1,301,277	1.085267	93,825	25,915	101,825	28,125
16.	EKG	13,829,736	35,271,252	0.392097	1,062,757	569,560	416,704	223,323
17.	EEG							
18.	Med. / Surg. Supplies	30,879,283	29,045,056	1.063151	3,024,615	1,661,646	3,215,622	1,766,581
19.	Drugs Charged to Patients	185,381,955	183,429,254	1.010646	11,161,259	3,036,522	11,280,082	3,068,849
20.	Renal Dialysis	6,666,006	10,422,032	0.639607	940,614		601,623	
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	267,808,234	102,282,019	2.618332	874,131	8,053,376	2,288,765	21,086,412
44.	Emergency	65,251,035	53,408,239	1.221741	72,142	5,408,966	88,139	6,608,356
45.	Observation	24,388,520	29,143,752	0.836835	1,780,789	1,682,279	1,490,227	1,407,790
46.	Total				55,615,882	40,037,642	36,187,940	42,015,722

* 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: 12/01/2019 To: 11/30/2020

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)	136,234,723			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	71,635			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,901.79			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,459			
3.	Program general inpatient routine cost (Line 1c X Line 2)	19,890,822			
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)	19,890,822			

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	18,536,273	8,667	2,138.72	2,157	4,613,219
9.	Coronary Care Unit					
10.	Burn ICU	7,547,561	1,352	5,582.52	148	826,213
11.	SICU	8,811,151	2,977	2,959.74	445	1,317,084
12.	Trauma ICU	17,053,408	2,519	6,769.91	396	2,680,884
13.	Neuro ICU	4,747,924	1,986	2,390.70	429	1,025,610
14.	Neonatal ICU	13,648,195	5,568	2,451.18	945	2,316,365
15.	Peds ICU					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	6,049,182	1,526	3,964.08	729	2,889,814
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					36,187,940
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					71,747,951

**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:	To:
		12/01/2019	11/30/2020

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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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: 12/01/2019 To: 11/30/2020

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	5,443,659	149,665,768	0.036372	11,714,198	287,754	426,069	10,466
2.	Recovery Room	364,366	12,648,850	0.028806	605,700	1,149,800	17,448	33,121
3.	Delivery and Labor Room							
4.	Anesthesiology	4,154,515	54,333,976	0.076463	4,765,016	2,959,332	364,347	226,279
5.	Radiology - Diagnostic	4,098,574	156,933,677	0.026117	5,785,417	8,464,995	151,098	221,080
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,247,112	134,806,135	0.016669	9,913,904	6,080,411	165,255	101,354
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	460,760	17,282,522	0.026660	2,193,198	504,363	58,471	13,446
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	64,293	35,271,252	0.001823	1,062,757	569,560	1,937	1,038
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,260,103	10,422,032	0.120908	940,614		113,728	
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	31,594,330	102,282,019	0.308894	874,131	8,053,376	270,014	2,487,640
44.	Emergency	4,641,124	53,408,239	0.086899	72,142	5,408,966	6,269	470,034
45.	Observation							
46.	Ancillary Total						1,574,636	3,564,458

* 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: 12/01/2019 To: 11/30/2020

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	15,050,218	71,635	210.10	10,459		2,197,436	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	256,589	8,667	29.61	2,157		63,869	
52.	Coronary Care Unit							
53.	Burn ICU							
54.	SICU	571,319	2,977	191.91	445		85,400	
55.	Trauma ICU	735,210	2,519	291.87	396		115,581	
56.	Neuro ICU							
57.	Neonatal ICU	165,071	5,568	29.65	945		28,019	
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)						2,490,305	
68.	Ancillary Total (from line 46)						1,574,636	3,564,458
69.	Total (Lines 67-68)						4,064,941	3,564,458

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: 12/01/2019 To: 11/30/2020	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		42,015,722
2.	Inpatient Operating Services (BHF Page 4, Line 25)	71,747,951	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)	4,064,941	3,564,458
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)	5,172,320	2,566,922
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	80,985,212	48,147,102
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	63.00%	37.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	55,615,882	40,037,642
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	36,926,306	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Burn ICU		
	H. SICU		
	I. Trauma ICU		
	J. Neuro ICU		
	K. Neonatal ICU		
	L. Peds ICU		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	92,542,188	40,037,642
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,447,516
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: 12/01/2019 To: 11/30/2020

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)	80,985,212	48,147,102
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	80,985,212	48,147,102
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)	80,985,212	48,147,102

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:	Medicaid Provider Number:
14-0124	0001
Program:	Period Covered by Statement:
Medicaid Hospital	From: 12/01/2019 To: 11/30/2020

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)	3,447,516
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(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
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: 12/01/2019 To: 11/30/2020

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:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 12/01/2019 To: 11/30/2020

Line No.	Cost Centers	G M E Cost (CMS 2552-10 W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10 W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	11,155,463	149,665,768	0.074536	11,714,198	287,754	873,129	21,448
2.	Recovery Room							
3.	Delivery and Labor Room	889,365	1,740,822	0.510888				
4.	Anesthesiology	4,354,679	54,333,976	0.080147	4,765,016	2,959,332	381,902	237,182
5.	Radiology - Diagnostic	2,800,733	156,933,677	0.017847	5,785,417	8,464,995	103,252	151,075
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,436,667	134,806,135	0.010657	9,913,904	6,080,411	105,652	64,799
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,223,052	17,282,522	0.070768	2,193,198	504,363	155,208	35,693
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,784,315	35,271,252	0.050588	1,062,757	569,560	53,763	28,813
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	142,410	183,429,254	0.000776	11,161,259	3,036,522	8,661	2,356
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	10,990,713	102,282,019	0.107455	874,131	8,053,376	93,930	865,376
44.	Emergency	11,455,641	53,408,239	0.214492	72,142	5,408,966	15,474	1,160,180
45.	Observation							
46.	Ancillary Total						1,790,971	2,566,922

* 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: 12/01/2019 To: 11/30/2020

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	15,209,964	71,635	212.33	10,459		2,220,759	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,351,164	8,667	271.28	2,157		585,151	
52.	Coronary Care Unit							
53.	Burn ICU	471,909	1,352	349.05	148		51,659	
54.	SICU	685,524	2,977	230.27	445		102,470	
55.	Trauma ICU							
56.	Neuro ICU	104,713	1,986	52.73	429		22,621	
57.	Neonatal ICU	1,256,560	5,568	225.68	945		213,268	
58.	Peds ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	388,138	1,526	254.35	729		185,421	
67.	Routine Total (lines 47-66)						3,381,349	
68.	Ancillary Total (from line 46)						1,790,971	2,566,922
69.	Total (Lines 67-68)						5,172,320	2,566,922

Preliminary

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2019 To: 11/30/2020

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	14,977	2	14,979
Newborn Days	731	(2)	729
Total Inpatient Revenue	92,542,188		92,542,188
Ancillary Revenue	55,615,882		55,615,882
Routine Revenue	36,926,306		36,926,306
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	20,226		20,226
Total Outpatient Revenue	40,037,642		40,037,642
Outpatient Received and Receivable			

Notes:

[illegible]