

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: 12/01/2020	To: 11/30/2021	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ Other (Specify)	☐ Corporation	☐ County	☐ Other (Specify)

Type of Hospital

☐ 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)

☐ 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 12/01/2020 and ending 11/30/2021 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: 12/01/2020 To: 11/30/2021

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	295	107,675		59,851	55.58%		15,950	5.21
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	32	11,680		8,962	76.73%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,647	56.40%			
8.	SICU	14	5,110		3,028	59.26%			
9.	Trauma ICU	12	4,380		2,972	67.85%			
10.	Neuro ICU	10	3,650		2,419	66.27%			
11.	Neonatal ICU	52	18,980		4,164	21.94%			
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,347				
22.	Total	423	154,395		84,390	54.66%		15,950	5.21
23.	Observation Bed Days				12,428				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,235			1,804	5.93
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,229				
6.	Coronary Care Unit								
7.	Burn ICU				45				
8.	SICU				303				
9.	Trauma ICU				295				
10.	Neuro ICU				240				
11.	Neonatal ICU				350				
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				520				
22.	Total				11,217	13.29%		1,804	5.93

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	20,440	68,636

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: 12/01/2020	To: 11/30/2021

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	80,424,032	172,305,307	0.466753	9,916,844	5,221,226	4,628,717	2,437,023
2.	Recovery Room	8,949,019	16,208,400	0.552122	582,000	722,700	321,335	399,019
3.	Delivery and Labor Room	9,468,698	2,471,167	3.831671				
4.	Anesthesiology	11,342,797	60,062,218	0.188851	4,148,904	1,842,672	783,525	347,990
5.	Radiology - Diagnostic	61,798,091	143,489,412	0.430680	4,852,352	5,521,137	2,089,811	2,377,843
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	61,611,362	144,395,058	0.426686	7,039,207	5,014,479	3,003,531	2,139,608
9.	Blood							
10.	Blood - Administration	6,887,037	12,720,467	0.541414	563,742	156,461	305,218	84,710
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,875,613	14,614,848	0.675725	1,157,171	66,441	781,929	44,896
13.	Physical Therapy	7,222,694	6,666,841	1.083376	442,049	113,705	478,905	123,185
14.	Occupational Therapy	2,594,269	2,261,600	1.147095	156,539	47,688	179,565	54,703
15.	Speech Pathology	1,747,791	1,514,832	1.153785	61,845	33,818	71,356	39,019
16.	EKG	14,685,717	40,333,293	0.364109	1,864,812	521,864	678,995	190,015
17.	EEG							
18.	Med. / Surg. Supplies	29,693,072	17,139,139	1.732472	1,433,209	643,860	2,482,994	1,115,469
19.	Drugs Charged to Patients	164,678,135	207,400,663	0.794010	9,757,574	4,671,292	7,747,611	3,709,053
20.	Renal Dialysis	6,302,257	12,341,346	0.510662	895,618	99,012	457,358	50,562
21.	Ambulance							
22.	Implants	9,095,281	19,015,159	0.478317	1,532,962	759,475	733,242	363,270
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	201,752,213	98,504,476	2.048153	41,331	523,831	84,652	1,072,886
44.	Emergency	63,127,360	52,230,500	1.208630	23,624	3,813,217	28,553	4,608,768
45.	Observation	23,577,656	27,449,644	0.858942	1,179,265	1,722,772	1,012,920	1,479,761
46.	Total				45,649,048	31,495,650	25,870,217	20,637,780

* 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: 12/01/2020 To: 11/30/2021

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)	135,776,033			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	72,279			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,878.50			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,235			
3.	Program general inpatient routine cost (Line 1c X Line 2)	15,469,448			
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)	15,469,448			

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	19,470,422	8,962	2,172.55	1,229	2,670,064
9.	Coronary Care Unit					
10.	Burn ICU	8,078,879	1,647	4,905.21	45	220,734
11.	SICU	8,638,630	3,028	2,852.92	303	864,435
12.	Trauma ICU	14,044,646	2,972	4,725.65	295	1,394,067
13.	Neuro ICU	5,292,172	2,419	2,187.75	240	525,060
14.	Neonatal ICU	12,090,340	4,164	2,903.54	350	1,016,239
15.	Peds ICU					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	6,409,002	1,347	4,757.98	520	2,474,150
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					25,870,217
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					50,504,414

**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: 12/01/2020 To: 11/30/2021

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: 12/01/2020 To: 11/30/2021

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants							
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							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* 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: 12/01/2020 To: 11/30/2021

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	SICU							
55.	Trauma ICU							
56.	Neuro ICU							
57.	Neonatal ICU							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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: 12/01/2020 To: 11/30/2021	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			20,637,780
2. Inpatient Operating Services (BHF Page 4, Line 25)		50,504,414	
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)			
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)		5,698,345	1,620,697
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		56,202,759	22,258,477
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		72.00%	28.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9. Ancillary Services (See Instructions)		45,649,048	31,495,650
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		18,009,382	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		4,402,567	
F. Coronary Care Unit			
G. Burn ICU		238,881	
H. SICU		574,018	
I. Trauma ICU		815,247	
J. Neuro ICU		388,548	
K. Neonatal ICU		953,762	
L. Peds ICU			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		855,745	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		71,887,198	31,495,650
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			24,921,612
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: 12/01/2020 To: 11/30/2021

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)	56,202,759	22,258,477
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	56,202,759	22,258,477
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)	56,202,759	22,258,477

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: 12/01/2020 To: 11/30/2021

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)	24,921,612
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: 12/01/2020 To: 11/30/2021

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: 12/01/2020 To: 11/30/2021

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	8,075,164	172,305,307	0.046865	9,916,844	5,221,226	464,753	244,693
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	7,652,020	60,062,218	0.127402	4,148,904	1,842,672	528,579	234,760
5.	Radiology - Diagnostic	3,346,602	143,489,412	0.023323	4,852,352	5,521,137	113,171	128,769
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	193,099	40,333,293	0.004788	1,864,812	521,864	8,929	2,499
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants							
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	8,446,789	98,504,476	0.085750	41,331	523,831	3,544	44,919
44.	Emergency	13,218,596	52,230,500	0.253082	23,624	3,813,217	5,979	965,057
45.	Observation							
46.	Ancillary Total						1,124,955	1,620,697

* 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: 12/01/2020 To: 11/30/2021

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	40,140,507	72,279	555.36	8,235		4,573,390	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	SICU							
55.	Trauma ICU							
56.	Neuro ICU							
57.	Neonatal ICU							
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)						4,573,390	
68.	Ancillary Total (from line 46)						1,124,955	1,620,697
69.	Total (Lines 67-68)						5,698,345	1,620,697

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid Hospital	Period Covered by Statement: From: 12/01/2020 To: 11/30/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	14,977	(4,280)	10,697
Newborn Days	731	(211)	520
Total Inpatient Revenue	92,542,188	(20,654,990)	71,887,198
Ancillary Revenue	55,615,882	(9,966,834)	45,649,048
Routine Revenue	36,926,306	(10,688,156)	26,238,150
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	20,226	214	20,440
Total Outpatient Revenue	40,037,642	(8,541,992)	31,495,650
Outpatient Received and Receivable			

Notes:

BHF Page 2 - added the observation days to col 4, line 23 Part I - Hospital

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

BHF Page 2 - Adjusted the discharges to agree so the ave length of stay agrees with Title XIX on the Medicare report
(11509 XIX days - 375 XIX nursery per Medicare report) / 1879 XIX discharges = 5.93 ave length of stay
(11217 Program days per IPCR - 520 Program Nursery) / 5.93 ave length of stay = 1804 program discharges

BHF Page 3 - Blood was reclassified to Blood Administration

BHF Page 3 - I/P & O/P Radiology-Diagnostic charges also include CT Scan, MRI, Nuclear Medicine and Radiology-Therapy charges per the IPCR & OPCR

BHF Page 3 - I/P & O/P Lab charges also include GI charges per the IPCR & OPCR

BHF Page 3 - I/P & O/P EKG charges also include Cardiolgy Cath and EEG charges per the IPCR & OPCR

BHF Page 3 - O/P Blood-Admin charges also include IV Therapy charges per the OPCR

BHF Page 3 - Reclassified I/P & O/P Delivery Room charges to Recovery Room per the IPCR & OPCR

BHF Page 3 - Agreed the I/P & O/P Clinic, ER and Observation charges to what's reported on the IPCR/OPCR

BHF Page 3 - Reclassified the O/P ASC charges from Clinic to OR

BHF Page 3 - IPCR states Clinic charges are \$531,154. The provider didn't report the IPCR Clinic charges on the cost report. However the total I/P Clinic charges per W/S C, Part I, Col 6 report Clinic as \$310,760. Since the Medicaid day % is 13.3%, reported \$310,760 * 13.3% as Clinic charges on the cost report.

BHF Page 3 - IPCR states \$99,012 of Hemodialysis charges; reclassified to Renal Dialysis from Clinic

BHF Page 4 - Agreed line 1a to W/S C, Part I, col 1, line 30. Added the observation days to line 1b.

BHF Page 6a & 6b - Professional fees not allowed as none on the IPCR

BHF Page 7 - Totals on line 10 agrees with the IPCR

BHF Page 4 & 6b & Supplemental 2b - Adjusted I/P days to the reallocated days on page 2

BHF Supplemental 2a & 2b - Agreed to W/S B, Part I, Col 25 of the Medicare report