Hospital Statement of Cost

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:** 12/01/2022	**To:** 11/30/2023

Type of Control

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

Type of Hospital

[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]	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 12/01/2022 and ending 11/30/2023 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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		69,428	64.48%		15,873	5.84
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	32	11,680		10,432	89.32%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,563	53.53%			
8.	SICU	14	5,110		2,777	54.34%			
9.	Trauma ICU	12	4,380		2,632	60.09%			
10.	Neuro ICU	10	3,650		2,500	68.49%			
11.	Neonatal ICU	58	21,170		3,416	16.14%			
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,863				
22.	**Total**	**429**	**156,585**		**94,611**	**60.42%**		**15,873**	**5.84**
23.	Observation Bed Days				9,913				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,766			1,411	5.92
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				833				
6.	Coronary Care Unit								
7.	Burn ICU				63				
8.	SICU				135				
9.	Trauma ICU				164				
10.	Neuro ICU								
11.	Neonatal ICU				393				
12.	Peds ICU								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				681				
22.	**Total**				**9,035**	**9.55%**		**1,411**	**5.92**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	18,564	866,474

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	89,698,814	213,235,178	0.420657	6,197,659	4,413,150	2,607,089	1,856,422
2.	Recovery Room	11,249,277	15,893,900	0.707773	359,500	590,550	254,444	417,975
3.	Delivery and Labor Room	9,796,855	6,338,422	1.545630				
4.	Anesthesiology	14,435,577	60,669,242	0.237939	2,317,328	1,453,392	551,383	345,819
5.	Radiology - Diagnostic	66,736,286	159,502,051	0.418404	2,860,090	4,590,352	1,196,673	1,920,622
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	83,613,993	171,033,168	0.488876	6,358,646	6,341,326	3,108,589	3,100,122
9.	Blood							
10.	Blood - Administration	8,794,703	16,571,464	0.530714	488,914	103,596	259,474	54,980
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,664,590	34,602,686	0.568297	3,065,043	981,610	1,741,855	557,846
13.	Physical Therapy	9,233,431	8,308,573	1.111314	304,408	158,745	338,293	176,416
14.	Occupational Therapy	4,259,667	4,247,162	1.002944	173,777	102,112	174,289	102,413
15.	Speech Pathology	2,163,848	2,791,105	0.775266	150,590	46,646	116,747	36,163
16.	EKG	33,804,364	76,283,817	0.443139	747,839	556,748	331,397	246,717
17.	EEG							
18.	Med. / Surg. Supplies	46,425,619	33,202,807	1.398244	2,162,840	1,040,797	3,024,178	1,455,288
19.	Drugs Charged to Patients	180,034,852	280,464,876	0.641916	5,995,458	5,122,360	3,848,580	3,288,125
20.	Renal Dialysis	8,876,156	17,956,703	0.494309	590,988		292,131	
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 Service Cost Centers							
43.	Clinic	235,545,423	136,556,703	1.724891	460,631	1,256,617	794,538	2,167,527
44.	Emergency	65,531,274	83,533,478	0.784491	33,853	6,086,028	26,557	4,774,434
45.	Observation	20,426,926	39,140,773	0.521884	711,577	2,558,407	371,361	1,335,192
46.	**Total**				**32,979,141**	**35,402,436**	**19,037,578**	**21,836,061**

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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)	160,926,679			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	79,341			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,028.29			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,766			
3.	Program general inpatient routine cost (Line 1c X Line 2)	13,723,410			
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)	13,723,410			

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	36,627,653	10,432	3,511.09	833	2,924,738
9.	Coronary Care Unit					
10.	Burn ICU	10,370,933	1,563	6,635.27	63	418,022
11.	SICU	10,609,169	2,777	3,820.37	135	515,750
12.	Trauma ICU	14,036,393	2,632	5,332.98	164	874,609
13.	Neuro ICU	5,800,228	2,500	2,320.09		
14.	Neonatal ICU	12,848,895	3,416	3,761.39	393	1,478,226
15.	Peds ICU					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	6,665,775	1,863	3,577.98	681	2,436,604
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					19,037,578
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**41,408,937**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		21,836,061
2.	Inpatient Operating Services (BHF Page 4, Line 25)	41,408,937	
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)	3,665,435	1,278,550
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**45,074,372**	**23,114,611**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	66.00%	34.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	32,979,141	35,402,436
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	16,505,362	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,709,386	
	F. Coronary Care Unit		
	G. Burn ICU	405,579	
	H. SICU	898,740	
	I. Trauma ICU	1,123,903	
	J. Neuro ICU		
	K. Neonatal ICU	2,386,273	
	L. Peds ICU		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	3,819,194	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	62,827,578	35,402,436
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		30,041,031
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	45,074,372	23,114,611
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	45,074,372	23,114,611
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)**	**45,074,372**	**23,114,611**

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

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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)	30,041,031
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient Amount (Col. 1x3A)
		(1)	(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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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	7,217,667	213,235,178	0.033848	6,197,659	4,413,150	209,778	149,376
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,540,340	60,669,242	0.107803	2,317,328	1,453,392	249,815	156,680
5.	Radiology - Diagnostic	3,008,257	159,502,051	0.018860	2,860,090	4,590,352	53,941	86,574
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	333,631	76,283,817	0.004374	747,839	556,748	3,271	2,435
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	6,607,859	136,556,703	0.048389	460,631	1,256,617	22,289	60,806
44.	Emergency	11,291,634	83,533,478	0.135175	33,853	6,086,028	4,576	822,679
45.	Observation							
46.	**Ancillary Total**						**543,670**	**1,278,550**

* 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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 12/01/2022 To: 11/30/2023

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	36,606,868	79,341	461.39	6,766		3,121,765	
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)**						**3,121,765**	
68.	**Ancillary Total (from line 46)**						**543,670**	**1,278,550**
69.	**Total (Lines 67-68)**						**3,665,435**	**1,278,550**

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-0124	0001	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 12/01/2022	To: 11/30/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,354		8,354
Newborn Days	681		681
Total Inpatient Revenue	62,827,579	(1)	62,827,578
Ancillary Revenue	32,979,141		32,979,141
Routine Revenue	29,848,438	(1)	29,848,437
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	199,289	(180,725)	18,564
Total Outpatient Revenue	35,402,436		35,402,436
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Part II-Program days agree with the IPCR dated 01/26/24; Reclassified 452 Intermediate ICU days to A&P; Reclassifed 6 Ped ICU days to ICU as no Beds reported for Ped ICU

BHF Page 2 - Adjusted the discharges to agree so the ave length of stay agrees with Title XIX on the Medicare report (9510 XIX days - 187 XIX nursery per Medicare report) / 1574 XIX discharges = 5.92 ave length of stay (9035 Program days per IPCR - 681 Program Nursery) / 5.92 ave length of stay = 1411 program discharges

BHF Page 2 - Adjusted the Part III-OP Program Stats to agree with the OPCR

BHF Page 3 - Blood Costs/Charges are reclassified to Blood Administration Costs/Charges

BHF Page 3 - Included the Implant Costs/Charges with Med Surg Supplies as not differentiated on the PCR

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 and Cardiac Cath Lab charges per the IPCR & OPCR

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

BHF Page 3 - IP & OP RT charges also include IV Therapy charges per the PCR

BHF Page 3 - IP & OP Clinic charges also contain Behavioral Health and Other charges from the PCR

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

BHF Page 3 - Total I/P and O/P charges agree with the IPCR and OPCR

BHF Page 4 - Agreed line 1a to W/S C, Part I, col 1, line 30. W/S D-1 contains RCE Disallowance which is not allowable for cost reporting purposes

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

BHF Page 7 - Routine Charges agree with the IPCR; spread the charges based upon the methodology used on BHF Page 4 and the amounts from W/S C, Part I, Col 8 of the Medicare report

Minor rounding adjustment