

# 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 Street		Medicaid Provider Number: 1
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 12/01/2007	To: 11/30/2008

## Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

## Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

## Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> 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 c 1 for the cost report beginning 12/01/2007 and ending 11/30/2008 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 \_\_\_\_\_

\_\_\_\_\_  
 Name (Typewritten)  
 Title \_\_\_\_\_  
 Date \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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:	14-0124	Medicaid Provider Number:	1
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2007 To: 11/30/2008

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	117,852		85,396	72.46%		23,343	4.93
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	34	12,444		8,071	64.86%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,928		1,884	64.34%			
8.	Surgical ICU	14	5,124		2,555	49.86%			
9.	Peds ICU	8	2,928		1,639	55.98%			
10.	Trauma ICU	12	4,392		3,292	74.95%			
11.	Neuro ICU	10	3,660		2,575	70.36%			
12.	Neonatal ICU	52	19,032		9,558	50.22%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,516		2,621	27.54%			
22.	<b>Total</b>	<b>486</b>	<b>177,876</b>		<b>117,591</b>	<b>66.11%</b>		<b>23,343</b>	<b>4.93</b>
23.	Observation Bed Days				1,327				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				26,499			8,311	5.10
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				3,331				
6.	Coronary Care Unit								
7.	Burn ICU				543				
8.	Surgical ICU				875				
9.	Peds ICU				1,268				
10.	Trauma ICU				1,171				
11.	Neuro ICU								
12.	Neonatal ICU				8,702				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				2,611				
22.	<b>Total</b>				<b>45,000</b>	<b>38.27%</b>		<b>8,311</b>	<b>5.10</b>

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	97,194	550,809

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

PRELIMINARY

Medicare Provider Number:	14-0124	Medicaid Provider Number:	1
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2007 To: 11/30/2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	31,109,573						
2.	Recovery Room	3,150,055						
3.	Delivery and Labor Room	7,931,757						
4.	Anesthesiology	4,391,073						
5.	Radiology - Diagnostic	8,837,414						
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	12,930,118						
9.	Blood							
10.	Blood - Administration	8,605,191						
11.	Intravenous Therapy	1,839,454						
12.	Respiratory Therapy	6,938,987						
13.	Physical Therapy	1,389,198						
14.	Occupational Therapy	515,818						
15.	Speech Pathology	201,837						
16.	EKG	2,605,389						
17.	EEG							
18.	Med. / Surg. Supplies	13,024,628						
19.	Drugs Charged to Patients	26,010,456						
20.	Renal Dialysis	152,854						
21.	Ambulance							
22.	Emergency	5,579,376						
23.	Total Ancillary/GME Inpatient Cost	135,213,178	116,297	1,162.654050	42,389		49,283,743	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	185,567,060						
28.	Plus Clinics	71,612,579						
29.	Plus Observation	1,878,395						
30.	Less Renal Dialysis	(5,132,205)						
31.	Total Outpatient Cost	253,925,829	550,809	461.005229		97,194		44,806,942
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	To zero Column 4-5				(42,389)	(97,194)		
44.	Emergency							
45.	Observation							
46.	<b>Total</b>						<b>49,283,743</b>	<b>44,806,942</b>

\* 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: 14-0124	Medicaid Provider Number: 1
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2007 To: 11/30/2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	122,638,726			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	86,723			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,414.14			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	26,499			
3.	Program general inpatient routine cost (Line 1c X Line 2)	37,473,296			
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)	37,473,296			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	18,353,289	8,071	2,273.98	3,331	7,574,627
9.	Coronary Care Unit					
10.	Burn ICU	3,676,299	1,884	1,951.33	543	1,059,572
11.	Surgical ICU	8,137,212	2,555	3,184.82	875	2,786,718
12.	Peds ICU	4,655,555	1,639	2,840.49	1,268	3,601,741
13.	Trauma ICU	12,603,917	3,292	3,828.65	1,171	4,483,349
14.	Neuro ICU	5,157,583	2,575	2,002.94		
15.	Neonatal ICU	16,660,748	9,558	1,743.12	8,702	15,168,630
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,997,430	2,621	1,525.15	2,611	3,982,167
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					49,283,743
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>125,413,843</b>

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

Medicare Provider Number: <b>14-0124</b>	Medicaid Provider Number: <b>1</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>12/01/2007</b> To: <b>11/30/2008</b>

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub I						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	Surgical ICU						
10.	Peds ICU						
11.	Trauma ICU						
12.	Neuro ICU						
13.	Neonatal 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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)		
23.	To zero Column 4-5								
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:	14-0124	Medicaid Provider Number:	1
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2007 To: 11/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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.	Emergency							
23.	Total Ancillary/GME Inpatient Cost	20,950,104	116,297	180.143116	42,389		7,636,087	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost							
28.	Plus Clinics							
29.	Plus Observation							
30.	Less Renal Dialysis							
31.	Total Outpatient Cost	20,922,976	550,809	37.985901		97,194		3,692,002
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
<b>Outpatient Ancillary Cost Centers</b>								
43.	To zero Column 4-5							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>						<b>7,636,087</b>	<b>3,692,002</b>

\* 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: 14-0124	Medicaid Provider Number: 1
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2007 To: 11/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Surgical ICU							
55.	Peds ICU							
56.	Trauma ICU							
57.	Neuro ICU							
58.	Neonatal ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						7,636,087	3,692,002
69.	<b>Total (Lines 67-68)</b>						7,636,087	3,692,002

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

**PRELIMINARY**

<b>Medicare Provider Number:</b> 14-0124	<b>Medicaid Provider Number:</b> 1
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 12/01/2007 To: 11/30/2008

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		44,806,942
2.	Inpatient Operating Services (BHF Page 4, Line 25)	125,413,843	
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)	7,636,087	3,692,002
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)	8,758,163	2,687,835
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>141,808,093</b>	<b>51,186,779</b>
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	73.00%	27.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)		44,806,942
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	70,901,579	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	8,711,811	
	F. Coronary Care Unit		
	G. Burn ICU	2,477,550	
	H. Surgical ICU	2,673,969	
	I. Peds ICU	4,601,625	
	J. Trauma ICU	3,238,763	
	K. Neuro ICU	2,757,913	
	L. Neonatal ICU	30,600,000	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,446,060	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>127,409,270</b>	<b>44,806,942</b>
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		(20,778,660)
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)	(15,168,422)	(5,610,238)

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0124	Medicaid Provider Number: 1
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2007 To: 11/30/2008

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)	141,808,093	51,186,779
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)	(15,168,422)	(5,610,238)
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	126,639,671	45,576,541
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, Sec. 115.2 (B)		
6.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>126,639,671</b>	<b>45,576,541</b>

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0124	Medicaid Provider Number: 1
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2007 To: 11/30/2008

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)
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)				20,778,660	20,778,660
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)				20,778,660	20,778,660

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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 1
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2007 To: 11/30/2008

**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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

**Part B. Program Data**

	General Service	Sub I Sub I	Sub II Sub II	Sub III Sub III
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 Sub I	Sub II Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. 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 Sub I	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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 1)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0124	Medicaid Provider Number:	1
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2007 To: 11/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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							
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.	Emergency							
23.	Total Ancillary/GME Inpatient Cost	5,771,819	116,297	49.629990	42,389		2,103,766	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	7,237,441		#DIV/0!				
28.	Plus Clinics	8,284,725		#DIV/0!				
29.	Plus Observation							
30.	Less Renal Dialysis	(289,914)		#DIV/0!				
31.	Total Outpatient Cost	15,232,252	550,809	27.654327		97,194		2,687,835
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	To zero Column 4-5							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>						<b>2,103,766</b>	<b>2,687,835</b>

\* 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:	1
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2007 To: 11/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics	12,404,695	86,723	143.04	26,499		3,790,417	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,119,558	8,071	138.71	3,331		462,043	
52.	Coronary Care Unit							
53.	Burn ICU	74,637	1,884	39.62	543		21,514	
54.	Surgical ICU	74,637	2,555	29.21	875		25,559	
55.	Peds ICU	238,839	1,639	145.72	1,268		184,773	
56.	Trauma ICU	918,037	3,292	278.87	1,171		326,557	
57.	Neuro ICU	74,637	2,575	28.99				
58.	Neonatal ICU	1,044,920	9,558	109.32	8,702		951,303	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	895,646	2,621	341.72	2,611		892,231	
67.	<b>Routine Total (lines 47-66)</b>						<b>6,654,397</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>2,103,766</b>	<b>2,687,835</b>
69.	<b>Total (Lines 67-68)</b>						<b>8,758,163</b>	<b>2,687,835</b>

