

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information **Revised PRELIMINARY**

Name of Hospital: Children's Hospital of Illinois		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Ave		Medicaid Provider Number: 16008
City: Peoria	State: Illinois	Zip: 61637
Period Covered by Statement:	From: 10/01/07	To: 09/30/08

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" 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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) Children's

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)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/07 and ending 09/30/08 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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	79	28,914		17,865	61.79%		3,438	9.48
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	12	4,392		3,232	73.59%			
6.	Coronary Care Unit								
7.	Premature ICU	35	12,810		11,485	89.66%			
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	126	46,116		32,582	70.65%		3,438	9.48
23.	Observation Bed Days				545				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics			596	12,096			2,324	6.85
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				1,072				
6.	Coronary Care Unit								
7.	Premature ICU				2,759				
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total			596	15,927	48.88%		2,324	6.85

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	75,169,030	223,805,681	0.335867	6,071,006		2,039,051	
2.	Recovery Room	3,627,929	25,046,578	0.144847	676,525		97,993	
3.	Delivery and Labor Room	7,553,787	10,096,656	0.748147	350		262	
4.	Anesthesiology	3,373,711	77,602,460	0.043474	2,888,658		125,582	
5.	Radiology - Diagnostic	71,492,529	420,909,661	0.169852	5,889,117		1,000,278	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	34,536,030	414,791,352	0.083261	9,034,910		752,256	
9.	Blood							
10.	Blood - Administration	5,616,601	12,031,594	0.466821	510,035		238,095	
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,896,180	90,515,846	0.109331	9,698,489		1,060,346	
13.	Physical Therapy	13,508,585	32,177,368	0.419816	221,178		92,854	
14.	Occupational Therapy							
15.	Speech Pathology	1,263,955	3,400,685	0.371677	143,944		53,501	
16.	EKG	3,322,826	27,499,707	0.120831	81,742		9,877	
17.	EEG	1,148,533	4,198,799	0.273538	400,757		109,622	
18.	Med. / Surg. Supplies	6,758,909	54,377,692	0.124296	3,337,108		414,789	
19.	Drugs Charged to Patients	33,411,639	149,912,350	0.222874	14,092,162		3,140,777	
20.	Renal Dialysis	1,609,822	5,158,523	0.312070	60,027		18,733	
21.	Ambulance	9,210,763	21,373,686	0.430939	1,624,716		700,153	
22.	Digestive Diseases	5,927,428	49,548,070	0.119630	54,558		6,527	
23.	Cardiac Cath Lab	23,342,265	117,127,948	0.199289	555,404		110,686	
24.	Special Clinics	499,737	825,762	0.605183	10,984		6,647	
25.	Sisters Clinic	3,047,949	3,085,021	0.987983	461		455	
26.	Neuro Diagnostic	1,127,135	1,840,817	0.612301	2,324		1,423	
27.	Lithotripsy	193,532	957,606	0.202100				
28.	Sleep Disorders	3,355,310	13,461,679	0.249249	142		35	
29.	Pain Program	2,203,387	3,544,383	0.621656				
30.	Comp Epilepsy	698,449	4,127,408	0.169222	2,234		378	
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							
44.	Emergency	24,038,305	82,470,080	0.291479	944,454		275,289	
45.	Observation	3,268,027	1,060,234	3.082364	58,402		180,016	
46.	Total				56,359,687		10,435,625	

* 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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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)	15,826,301			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	18,410			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	859.66			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	12,096			
3.	Program general inpatient routine cost (Line 1c X Line 2)	10,398,447			
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)	596			
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)	10,398,447			

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	5,154,830	3,232	1,594.94	1,072	1,709,776
9.	Coronary Care Unit					
10.	Premature ICU	15,416,844	11,485	1,342.35	2,759	3,703,544
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					10,435,625
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					26,247,392

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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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.	Premature ICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
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)
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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	150,000	77,602,460	0.001933	2,888,658		5,584	
5.	Radiology - Diagnostic	2,056,946	420,909,661	0.004887	5,889,117		28,780	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,703	90,515,846	0.000229	9,698,489		2,221	
13.	Physical Therapy	492,768	32,177,368	0.015314	221,178		3,387	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	520,245	27,499,707	0.018918	81,742		1,546	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	70	21,373,686	0.000003	1,624,716		5	
22.	Digestive Diseases							
23.	Cardiac Cath Lab							
24.	Special Clinics	177,365	825,762	0.214789	10,984		2,359	
25.	Sisters Clinic	741	3,085,021	0.000240	461			
26.	Neuro Diagnostic	301,243	1,840,817	0.163646	2,324		380	
27.	Lithotripsy							
28.	Sleep Disorders	759,621	13,461,679	0.056428	142		8	
29.	Pain Program	195,066	3,544,383	0.055035				
30.	Comp Epilepsy	436,057	4,127,408	0.105649	2,234		236	
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	3,243,794	82,470,080	0.039333	944,454		37,148	
45.	Observation							
46.	Ancillary Total						81,654	

* 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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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	97,218	18,410	5.28	12,096		63,867	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	27,773	3,232	8.59	1,072		9,208	
52.	Coronary Care Unit							
53.	Premature ICU	66,791	11,485	5.82	2,759		16,057	
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						89,132	
68.	Ancillary Total (from line 46)						81,654	
69.	Total (Lines 67-68)						170,786	

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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	26,247,392	
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)	170,786	
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)	1,945,245	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	28,363,423	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	56,359,687	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	15,570,447	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	3,335,763	
	F. Coronary Care Unit		
	G. Premature ICU	7,932,211	
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	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)	83,198,108	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		54,834,685
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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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)	28,363,423	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	28,363,423	
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.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	28,363,423	

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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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)	54,834,685
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 (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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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)

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	5,823,278	223,805,681	0.026019	6,071,006		157,962	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	326,629	77,602,460	0.004209	2,888,658		12,158	
5.	Radiology - Diagnostic	5,628,140	420,909,661	0.013371	5,889,117		78,743	
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	132,427	4,198,799	0.031539	400,757		12,639	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Digestive Diseases							
23.	Cardiac Cath Lab							
24.	Special Clinics							
25.	Sisters Clinic	1,844,283	3,085,021	0.597819	461		276	
26.	Neuro Diagnostic							
27.	Lithotripsy							
28.	Sleep Disorders							
29.	Pain Program							
30.	Comp Epilepsy							
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							
44.	Emergency	5,274,185	82,470,080	0.063953	944,454		60,401	
45.	Observation							
46.	Ancillary Total						322,179	

* 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)

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,886,248	18,410	102.46	12,096		1,239,356	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	550,975	3,232	170.47	1,072		182,744	
52.	Coronary Care Unit							
53.	Premature ICU	836,602	11,485	72.84	2,759		200,966	
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						1,623,066	
68.	Ancillary Total (from line 46)						322,179	
69.	Total (Lines 67-68)						1,945,245	

