

# 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: 0001
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 12/01/2008	To: 11/30/2009

**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 0001 for the cost report beginning 12/01/2008 and ending 11/30/2009 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:	0001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2008 To: 11/30/2009

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	117,530		87,490	74.44%		23,835	4.82
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	34	12,410		6,544	52.73%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		2,066	70.75%			
8.	Surgical ICU	14	5,110		2,691	52.66%			
9.	Peds ICU	8	2,920		1,481	50.72%			
10.	Trauma ICU	12	4,380		2,734	62.42%			
11.	Neuro ICU	10	3,650		2,630	72.05%			
12.	Neonatal ICU	52	18,980		9,307	49.04%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,490		2,041	21.51%			
22.	<b>Total</b>	<b>486</b>	<b>177,390</b>		<b>116,984</b>	<b>65.95%</b>		<b>23,835</b>	<b>4.82</b>
23.	Observation Bed Days				1,709				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				30,623			8,341	5.52
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				3,199				
6.	Coronary Care Unit								
7.	Burn ICU				660				
8.	Surgical ICU				727				
9.	Peds ICU				976				
10.	Trauma ICU				1,011				
11.	Neuro ICU				128				
12.	Neonatal ICU				8,758				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,918				
22.	<b>Total</b>				<b>48,000</b>	<b>41.03%</b>		<b>8,341</b>	<b>5.52</b>

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	95,599	602,753

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

PRELIMINARY

Medicare Provider Number:	14-0124	Medicaid Provider Number:	0001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2008 To: 11/30/2009

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	32,235,266						
2.	Recovery Room	3,373,169						
3.	Delivery and Labor Room	6,804,468						
4.	Anesthesiology	3,595,530						
5.	Radiology - Diagnostic	8,446,248						
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	11,703,334						
9.	Blood							
10.	Blood - Administration	5,874,625						
11.	Intravenous Therapy	1,364,242						
12.	Respiratory Therapy	7,243,865						
13.	Physical Therapy	1,476,348						
14.	Occupational Therapy	509,792						
15.	Speech Pathology	351,669						
16.	EKG	2,076,746						
17.	EEG							
18.	Med. / Surg. Supplies	13,662,270						
19.	Drugs Charged to Patients	28,154,961						
20.	Renal Dialysis	2,108,264						
21.	Ambulance							
22.	Emergency	5,321,800						
23.	Total Ancillary/GME Inpatient Cost	134,302,597	116,652	1,151.309853	46,082		53,054,661	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	188,207,722						
28.	Plus Clinics	63,640,400						
29.	Plus Observation	2,350,200						
30.	Less Renal Dialysis	(3,610,387)						
31.	Total Outpatient Cost	250,587,935	602,753	415.739009		95,599		39,744,234
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				(46,082)	(95,599)		
44.	Emergency							
45.	Observation							
46.	<b>Total</b>						<b>53,054,661</b>	<b>39,744,234</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: 0001
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2008 To: 11/30/2009

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)	120,760,781			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	89,199			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,353.84			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	30,623			
3.	Program general inpatient routine cost (Line 1c X Line 2)	41,458,642			
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)	41,458,642			

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	17,676,780	6,544	2,701.22	3,199	8,641,203
9.	Coronary Care Unit					
10.	Burn ICU	3,847,422	2,066	1,862.26	660	1,229,092
11.	Surgical ICU	7,966,645	2,691	2,960.48	727	2,152,269
12.	Peds ICU	4,558,796	1,481	3,078.19	976	3,004,313
13.	Trauma ICU	12,363,423	2,734	4,522.10	1,011	4,571,843
14.	Neuro ICU	5,332,791	2,630	2,027.68	128	259,543
15.	Neonatal ICU	14,538,763	9,307	1,562.13	8,758	13,681,135
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,007,924	2,041	1,963.71	1,918	3,766,396
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					53,054,661
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>131,819,097</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>0001</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>12/01/2008</b> To: <b>11/30/2009</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: 0001
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2008 To: 11/30/2009

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	34,733,859	116,652	297.756224	46,082		13,721,202	
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	22,939,387	602,753	38.057690		95,599		3,638,277
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>13,721,202</b>	<b>3,638,277</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:	0001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2008 To: 11/30/2009

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>						13,721,202	3,638,277
69.	<b>Total (Lines 67-68)</b>						13,721,202	3,638,277

**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> 0001
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 12/01/2008 To: 11/30/2009

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		39,744,234
2.	Inpatient Operating Services (BHF Page 4, Line 25)	131,819,097	
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)	13,721,202	3,638,277
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)	10,460,509	2,644,079
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>156,000,808</b>	<b>46,026,590</b>
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	77.00%	23.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)		39,744,234
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	96,535,835	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	10,446,138	
	F. Coronary Care Unit		
	G. Burn ICU	2,715,000	
	H. Surgical ICU	4,515,000	
	I. Peds ICU	3,518,738	
	J. Trauma ICU	5,515,350	
	K. Neuro ICU	3,522,694	
	L. Neonatal ICU	29,171,250	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,115,400	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>157,055,405</b>	<b>39,744,234</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)		(5,227,759)
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)	(4,025,374)	(1,202,385)

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0124	Medicaid Provider Number: 0001
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2008 To: 11/30/2009

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)	156,000,808	46,026,590
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)	(4,025,374)	(1,202,385)
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	151,975,434	44,824,205
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>151,975,434</b>	<b>44,824,205</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: 0001
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2008 To: 11/30/2009

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	Sum of Columns 1 - 4
		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)				5,227,759	5,227,759
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)				5,227,759	5,227,759

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		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(1)	(2A)	(2B)	(3A)
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: 12/01/2008 To: 11/30/2009

**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:	0001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2008 To: 11/30/2009

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	6,520,751	116,652	55.899179	46,082		2,575,946	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	7,774,429						
28.	Plus Clinics	9,103,643						
29.	Plus Observation							
30.	Less Renal Dialysis	(207,116)						
31.	Total Outpatient Cost	16,670,956	602,753	27.658022		95,599		2,644,079
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>2,575,946</b>	<b>2,644,079</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:	0001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2008 To: 11/30/2009

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	13,630,859	89,199	152.81	30,623		4,679,501	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,230,222	6,544	187.99	3,199		601,380	
52.	Coronary Care Unit							
53.	Burn ICU	82,015	2,066	39.70	660		26,202	
54.	Surgical ICU	82,015	2,691	30.48	727		22,159	
55.	Peds ICU	262,448	1,481	177.21	976		172,957	
56.	Trauma ICU	1,008,783	2,734	368.98	1,011		373,039	
57.	Neuro ICU	82,015	2,630	31.18	128		3,991	
58.	Neonatal ICU	1,148,207	9,307	123.37	8,758		1,080,474	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	984,178	2,041	482.20	1,918		924,860	
67.	<b>Routine Total (lines 47-66)</b>						<b>7,884,563</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>2,575,946</b>	<b>2,644,079</b>
69.	<b>Total (Lines 67-68)</b>						<b>10,460,509</b>	<b>2,644,079</b>

