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:** 12/01/2009 / **To:** 11/30/2010

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	[ ]	DHS - Office of Rehabilitation Services
[ ]	Medicaid Sub I	[ ]	Medicaid Sub III	[ ]	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 o 0001 for the cost report beginning 12/01/2009 and ending 11/30/2010 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Signed (Officer or Administrator of Provider(s)):

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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 12/01/2009 To: 11/30/2010

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		81,402	69.26%		23,763	4.62
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	32	11,680		8,127	69.58%			
6.	Coronary Care Unit								
7.	Burn ICU	8	2,920		1,421	48.66%			
8.	Surgical ICU	14	5,110		2,727	53.37%			
9.	Peds ICU	10	3,650		1,403	38.44%			
10.	Trauma ICU	12	4,380		2,925	66.78%			
11.	Neuro ICU	10	3,650		2,634	72.16%			
12.	Neonatal ICU	52	18,980		9,055	47.71%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	26	9,490		1,937	20.41%			
22.	**Total**	**486**	**177,390**		**111,631**	**62.93%**		**23,763**	**4.62**
23.	Observation Bed Days				1,634				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				27,359			7,404	5.82
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				3,684				
6.	Coronary Care Unit								
7.	Burn ICU				371				
8.	Surgical ICU				946				
9.	Peds ICU				981				
10.	Trauma ICU				872				
11.	Neuro ICU				167				
12.	Neonatal ICU				8,741				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,879				
22.	**Total**				**45,000**	**40.31%**		**7,404**	**5.82**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	98,480	621,365

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: 12/01/2009 To: 11/30/2010

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	34,611,114						
2.	Recovery Room	3,791,483						
3.	Delivery and Labor Room	6,561,280						
4.	Anesthesiology	3,164,555						
5.	Radiology - Diagnostic	12,910,015						
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	12,746,134						
9.	Blood							
10.	Blood - Administration	6,454,444						
11.	Intravenous Therapy	1,294,820						
12.	Respiratory Therapy	8,479,941						
13.	Physical Therapy	1,541,500						
14.	Occupational Therapy	489,869						
15.	Speech Pathology	406,533						
16.	EKG	1,781,837						
17.	EEG							
18.	Med. / Surg. Supplies	23,845,847						
19.	Drugs Charged to Patients	28,945,714						
20.	Renal Dialysis	2,076,402						
21.	Ambulance							
22.	Emergency	5,137,632						
23.	Total Ancillary/GME Inpatient Cost	154,239,120	111,328	1,385.447686	43,121		59,741,890	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	190,818,927						
28.	Plus Clinics	71,262,670						
29.	Plus Observation	2,337,176						
30.	Less Renal Dialysis	(4,005,477)						
31.	Total Outpatient Cost	260,413,296	621,365	419.098752		98,480		41,272,845
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
	Outpatient Service Cost Centers							
43.	To zero Column 4-5				(43,121)	(98,480)		
44.	Emergency							
45.	Observation							
46.	**Total**						**59,741,890**	**41,272,845**

* 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:	12/01/2009	To:	11/30/2010

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)	116,992,684			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	83,036			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,408.94			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	27,359			
3.	Program general inpatient routine cost (Line 1c X Line 2)	38,547,189			
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)	38,547,189			

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	17,567,287	8,127	2,161.60	3,684	7,963,334
9.	Coronary Care Unit					
10.	Burn ICU	4,007,748	1,421	2,820.37	371	1,046,357
11.	Surgical ICU	7,526,627	2,727	2,760.04	946	2,610,998
12.	Peds ICU	3,838,777	1,403	2,736.12	981	2,684,134
13.	Trauma ICU	12,387,742	2,925	4,235.13	872	3,693,033
14.	Neuro ICU	5,158,488	2,634	1,958.42	167	327,056
15.	Neonatal ICU	14,614,571	9,055	1,613.98	8,741	14,107,799
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,160,574	1,937	1,631.69	1,879	3,065,946
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					59,741,890
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**133,787,736**

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: 12/01/2009 To: 11/30/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 12/01/2009 To: 11/30/2010

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	29,375,228	111,328	263.861993	43,121		11,377,993	
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	27,456,561	621,365	44.187492		98,480		4,351,584
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	To zero Column 4-5							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**						**11,377,993**	**4,351,584**

* 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: 12/01/2009 To: 11/30/2010

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.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**						**11,377,993**	**4,351,584**
69.	**Total (Lines 67-68)**						**11,377,993**	**4,351,584**

Rev. 10 / 08

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: 12/01/2009 To: 11/30/2010

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		41,272,845
2.	Inpatient Operating Services (BHF Page 4, Line 25)	133,787,736	
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)	11,377,993	4,351,584
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)	9,491,849	2,453,073
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**154,657,578**	**48,077,502**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	76.00%	24.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)		41,272,845
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	84,874,324	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	10,487,250	
	F. Coronary Care Unit		
	G. Burn ICU	1,256,250	
	H. Surgical ICU	3,154,125	
	I. Peds ICU	3,465,000	
	J. Trauma ICU	3,943,000	
	K. Neuro ICU	3,881,250	
	L. Neonatal ICU	21,397,500	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	990,000	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	133,448,699	41,272,845
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)		(28,013,536)
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)	(21,290,287)	(6,723,249)

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: 12/01/2009 To: 11/30/2010

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)	154,657,578	48,077,502
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)	(21,290,287)	(6,723,249)
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	133,367,291	41,354,253
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)**	**133,367,291**	**41,354,253**

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 / 08

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: 12/01/2009 To: 11/30/2010

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)	5,227,759
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	12/01/20(to 11/30/2009		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period			5,227,759		5,227,759
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)				28,013,536	28,013,536
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**			5,227,759	28,013,536	33,241,295

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)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended 11/30/2009					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0124	**0001**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 12/01/2009 To: 11/30/2010**

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:	Medicaid Provider Number:
14-0124	0001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 12/01/2009 To: 11/30/2010

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	6,110,436	111,328	54.886785	43,121		2,366,773	
24.	/ Total days [net of Nursery]							
25.	X Medicaid days [net of Nursery]							
26.								
27.	Total Ancillary/GME Outpatient Cost	7,201,509						
28.	Plus Clinics	8,477,486						
29.	Plus Observation							
30.	Less Renal Dialysis	(201,197)						
31.	Total Outpatient Cost	15,477,798	621,365	24.909350		98,480		2,453,073
32.	/ Total visits X Medicaid visits							
33.								
34.								
35.								
36.								
37.								
38.								
39.								
40.								
41.								
42.	Other							
	Outpatient Ancillary Centers							
43.	To zero Column 4-5							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**						**2,366,773**	**2,453,073**

* 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: 12/01/2009 To: 11/30/2010

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	12,693,319	83,036	152.87	27,359		4,182,370	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,145,606	8,127	140.96	3,684		519,297	
52.	Coronary Care Unit							
53.	Burn ICU	76,374	1,421	53.75	371		19,941	
54.	Surgical ICU	76,374	2,727	28.01	946		26,497	
55.	Peds ICU	244,396	1,403	174.20	981		170,890	
56.	Trauma ICU	939,397	2,925	321.16	872		280,052	
57.	Neuro ICU	76,374	2,634	29.00	167		4,843	
58.	Neonatal ICU	1,069,232	9,055	118.08	8,741		1,032,137	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	916,485	1,937	473.15	1,879		889,049	
67.	**Routine Total (lines 47-66)**						**7,125,076**	
68.	**Ancillary Total (from line 46)**						**2,366,773**	**2,453,073**
69.	**Total (Lines 67-68)**						**9,491,849**	**2,453,073**

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: 12/01/2009 To: 11/30/2010**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	43,121		43,121
Newborn Days	1,879		1,879
Total Inpatient Revenue	133,448,699		133,448,699
Ancillary Revenue			
Routine Revenue	133,448,699		133,448,699
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	98,480		98,480
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes: