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: University of Chicago - Children's Hospital	**Medicare Provider Number:** 14-0088
Street: 5841 South Maryland Avenue	**Medicaid Provider Number:** 3466
City: Chicago	**State:** Illinois / **Zip:** 60637
Period Covered by Statement:	**From:** 07/01/2010 / **To:** 06/30/2011

Type of Control

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

Type of Hospital

	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation	XXXX	Other (Specify) Children's

Health Care Program

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

XXXX	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		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)) University of Chicago - Childr 3466 for the cost report beginning 07/01/2010 and ending 06/30/2011 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

Email Address

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

Name (Typewritten)

Title

Date

Telephone Number

Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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	60	21,900		14,285	65.23%		4,564	8.53
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		4,836	66.25%			
6.	Coronary Care Unit	10	3,650		1,557	42.66%			
7.	Burn ICU	2	730		662	90.68%			
8.	Nursery Special Care	24	8,760		4,819	55.01%			
9.	Nursery ICU	47	17,155		12,790	74.56%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,935		536	7.73%			
22.	**Total**	**182**	**66,430**		**39,485**	**59.44%**		**4,564**	**8.53**
23.	Observation Bed Days				389				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,196			2,616	9.24
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,020				
6.	Coronary Care Unit				10				
7.	Burn ICU				267				
8.	Nursery Special Care				3,098				
9.	Nursery ICU				9,570				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				414				
22.	**Total**				**24,575**	**62.24%**		**2,616**	**9.24**

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:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	71,992,005	289,031,548	0.249080	14,962,602		3,726,885	
2.	Recovery Room							
3.	Delivery and Labor Room	9,162,251	18,950,815	0.483475				
4.	Anesthesiology	8,673,596	94,533,811	0.091751	4,722,384		433,283	
5.	Radiology - Diagnostic	40,093,745	126,239,920	0.317600	4,683,593		1,487,509	
6.	Radiology - Therapeutic	12,783,301	69,985,476	0.182656	64,150		11,717	
7.	Nuclear Medicine							
8.	Laboratory	48,217,639	354,374,434	0.136064	13,624,477		1,853,801	
9.	Blood							
10.	Blood - Administration	17,859,182	104,098,492	0.171560	5,544,499		951,214	
11.	Intravenous Therapy							
12.	Respiratory Therapy	18,282,944	134,859,079	0.135571	47,742,743		6,472,531	
13.	Physical Therapy	8,535,124	22,131,279	0.385659	1,361,223		524,968	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	15,780,843	90,833,618	0.173734	1,727,143		300,063	
17.	EEG	4,579,274	11,317,178	0.404630	958,725		387,929	
18.	Med. / Surg. Supplies	13,908,537	64,351,949	0.216132	855,946		184,997	
19.	Drugs Charged to Patients	82,074,273	512,490,709	0.160148	24,685,602		3,953,350	
20.	Renal Dialysis	6,475,888	33,675,358	0.192303	113,694		21,864	
21.	Ambulance	4,132,498	4,145,272	0.996918	6,039		6,020	
22.	Brace & Plaster Room	156,785	657,544	0.238440	7,114		1,696	
23.	Kidney Acquistion	4,321,723	4,546,043	0.950656	202,982		192,966	
24.	Liver Acquistion	3,765,324	4,202,453	0.895982	178,598		160,021	
25.	Heart Acquistion	2,091,253	3,463,978	0.603714				
26.	Pancreas Acquistion	464,408	452,271	1.026836				
27.	Implants Charged to Patients	38,794,368	114,829,169	0.337844	3,528,262		1,192,002	
28.	Lung Acquisition	1,534,147	893,582	1.716851				
29.	Other							
30.	CT Scan	7,416,606	128,669,791	0.057641	2,018,635		116,356	
31.	MRI	5,636,536	66,598,643	0.084634	1,497,642		126,751	
32.	Cardiac Catheterization	5,753,883	51,869,980	0.110929	623,104		69,120	
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	90,461,931	190,867,311	0.473952	3,358,972		1,591,991	
44.	Emergency	30,228,478	202,371,917	0.149371	232,008		34,655	
45.	Observation	3,371,057	6,603,016	0.510533				
46.	**Total**				**132,700,137**		**23,801,689**	

* 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:	Medicaid Provider Number:		
14-0088	3466		
Program:	**Period Covered by Statement:**		
Medicaid-Hospital	From: 07/01/2010	To:	06/30/2011

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	19,203,279			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	14,674			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,308.64			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,196			
3.	Program general inpatient routine cost (Line 1c X Line 2)	13,342,893			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	13,342,893			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	8,316,796	4,836	1,719.77	1,020	1,754,165
9.	Coronary Care Unit	2,996,654	1,557	1,924.63	10	19,246
10.	Burn ICU	1,197,967	662	1,809.62	267	483,169
11.	Nursery Special Care	4,462,993	4,819	926.12	3,098	2,869,120
12.	Nursery ICU	26,277,962	12,790	2,054.57	9,570	19,662,235
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	288,061	536	537.43	414	222,496
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					23,801,689
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**62,155,013**

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:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Brace & Plaster Room							
23.	Kidney Acquistion							
24.	Liver Acquistion							
25.	Heart Acquistion							
26.	Pancreas Acquistion							
27.	Implants Charged to Patients							
28.	Lung Acquisition							
29.	Other							
30.	CT Scan							
31.	MRI							
32.	Cardiac Catheterization							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
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)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	62,155,013	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	6,257,530	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**68,412,543**	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	132,700,137	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	46,696,216	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,789,039	
	F. Coronary Care Unit		
	G. Burn ICU	1,507,264	
	H. Nursery Special Care	8,349,088	
	I. Nursery ICU	44,361,372	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,201,456	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	239,604,572	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		171,192,029
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:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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)	68,412,543	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	68,412,543	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**68,412,543**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	**Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	171,192,029
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		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					
4.	**Total (Sum of Lines 1 - 3)**					

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

Medicare Provider Number:	**Medicaid Provider Number:**
14-0088	**3466**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2010 To: 06/30/2011**

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
1.	Operating Room	3,435,432	289,031,548	0.011886	14,962,602		177,845	
2.	Recovery Room							
3.	Delivery and Labor Room	1,299,113	18,950,815	0.068552				
4.	Anesthesiology	971,929	94,533,811	0.010281	4,722,384		48,551	
5.	Radiology - Diagnostic	1,241,375	126,239,920	0.009833	4,683,593		46,054	
6.	Radiology - Therapeutic	866,076	69,985,476	0.012375	64,150		794	
7.	Nuclear Medicine							
8.	Laboratory	3,012,017	354,374,434	0.008500	13,624,477		115,808	
9.	Blood							
10.	Blood - Administration	269,446	104,098,492	0.002588	5,544,499		14,349	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	176,325	90,833,618	0.001941	1,727,143		3,352	
17.	EEG	923,814	11,317,178	0.081629	958,725		78,260	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	446,689	33,675,358	0.013265	113,694		1,508	
21.	Ambulance							
22.	Brace & Plaster Room							
23.	Kidney Acquistion							
24.	Liver Acquistion							
25.	Heart Acquistion							
26.	Pancreas Acquistion							
27.	Implants Charged to Patients							
28.	Lung Acquisition							
29.	Other							
30.	CT Scan	1,260,621	128,669,791	0.009797	2,018,635		19,777	
31.	MRI	654,368	66,598,643	0.009826	1,497,642		14,716	
32.	Cardiac Catheterization	64,251	51,869,980	0.001239	623,104		772	
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	13,491,530	190,867,311	0.070685	3,358,972		237,429	
44.	Emergency	4,580,576	202,371,917	0.022634	232,008		5,251	
45.	Observation							
46.	**Ancillary Total**						**764,466**	

* 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:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	5,235,683	14,674	356.79	10,196		3,637,831	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	716,714	4,836	148.20	1,020		151,164	
52.	Coronary Care Unit	99,179	1,557	63.70	10		637	
53.	Burn ICU	14,214	662	21.47	267		5,732	
54.	Nursery Special Care	461,907	4,819	95.85	3,098		296,943	
55.	Nursery ICU	1,741,774	12,790	136.18	9,570		1,303,243	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	126,252	536	235.54	414		97,514	
67.	**Routine Total (lines 47-66)**						**5,493,064**	
68.	**Ancillary Total (from line 46)**						**764,466**	
69.	**Total (Lines 67-68)**						**6,257,530**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3466
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	24,161		24,161
Newborn Days	414		414
Total Inpatient Revenue	235,233,183	4,371,389	239,604,572
Ancillary Revenue	128,328,748	4,371,389	132,700,137
Routine Revenue	106,904,435		106,904,435
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Spread between Actue & Children's Hospital.
Observation Bed Days were taken from filed S-3 & spread between Actue & Children's Hospital.
BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
GME Costs were adjusted to filed W/S B, Pt 1, Col 25.
Renal Dialysis costs and charges on BHF page 3 include Home Program Dialysis.

Revised at 01/04/2013 by Provider to include previously omitted cost centers.