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: Children's Hospital of Wisconsin, Inc.		**Medicare Provider Number:** 52-3300	
Street: 9000 W. Wisconsin Avenue		**Medicaid Provider Number:** 13029	
City: Milwaukee	**State:** WI	**Zip:** 53201-1997	
Period Covered by Statement:	**From:** 01/01/2013	**To:** 12/31/2013	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX 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 XXXX	Other (Specify) Children's Hospital

Health Care Program

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

XXXX 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)) Children's Hospital of Wiscons 13029 for the cost report beginning 01/01/2013 and ending 12/31/2013 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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	157	57,305		30,362	52.98%		12,382	5.81
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	115	41,975		35,743	85.15%			
6.	Coronary Care Unit								
7.	HOT Unit	24	8,760		5,870	67.01%			
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**	**296**	**108,040**		**71,975**	**66.62%**		**12,382**	**5.81**
23.	Observation Bed Days								

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				421			155	6.18
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				428				
6.	Coronary Care Unit								
7.	HOT Unit				109				
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**				**958**	**1.33%**		**155**	**6.18**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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	23,273,381	35,112,275	0.662827	358,813	166,939	237,831	110,652
2.	Recovery Room	3,711,804	12,782,119	0.290390	48,733	120,845	14,152	35,092
3.	Delivery and Labor Room							
4.	Anesthesiology	1,804,120	12,662,000	0.142483	67,342	68,553	9,595	9,768
5.	Radiology - Diagnostic	21,208,332	41,177,248	0.515050	247,108	180,554	127,273	92,994
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,063,139	1,634,698	0.650358	1,395	17,929	907	11,660
8.	Laboratory	29,423,233	109,102,114	0.269685	921,827	1,172,895	248,603	316,312
9.	Blood							
10.	Blood - Administration	5,104,628	8,958,338	0.569819	92,421	9,936	52,663	5,662
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,914,234	40,494,579	0.244829	251,783	105,615	61,644	25,858
13.	Physical Therapy	6,039,220	11,839,447	0.510093	69,194	3,065	35,295	1,563
14.	Occupational Therapy							
15.	Speech Pathology	4,642,734	7,172,565	0.647291	20,777	41,320	13,449	26,746
16.	EKG	10,323,019	12,605,778	0.818912	62,160	111,362	50,904	91,196
17.	EEG	1,897,975	5,962,788	0.318303	60,023	19,010	19,106	6,051
18.	Med. / Surg. Supplies	22,617,920	122,575,912	0.184522	1,515,276	311,910	279,602	57,554
19.	Drugs Charged to Patients	41,756,417	109,436,066	0.381560	1,205,393	568,905	459,930	217,071
20.	Renal Dialysis	1,115,703	4,338,555	0.257160				
21.	Ambulance							
22.	Psychiatry	3,132,689	2,720,550	1.151491				
23.	Transport	6,164,814	5,573,782	1.106038	77,401		85,608	
24.	Dental	5,248,871	7,932,870	0.661661				
25.	GI Services	3,706,118	2,333,449	1.588258		4,793		7,613
26.	Genetics	2,218,480	844,136	2.628107		3,466		9,109
27.	Child Development	832,045	334,384	2.488292		422		1,050
28.	Child Protection Center	2,636,744	1,199,293	2.198582				
29.	Home Program Dialysis	279,295	151,698	1.841125				
30.	Kidney Acquisition	718,798	808,391	0.889171				
31.	Heart Acquisition	950,742	1,115,959	0.851951				
32.	Liver Acquisition	321,285	274,019	1.172492				
33.	CT Scan	1,402,266	8,991,916	0.155947	32,157	94,468	5,015	14,732
34.	MRI	2,360,021	18,027,578	0.130912	124,583	220,539	16,309	28,871
35.	Cardiac Cath	3,702,260	8,476,170	0.436785	105,717	53,891	46,176	23,539
36.	Implant Dev. Charged	17,753,772	8,955,196	1.982511				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	40,653,110	33,754,216	1.204386	4,799	343,736	5,780	413,991
44.	Emergency	12,861,025	22,312,799	0.576397	26,876	35,716	15,491	20,587
45.	Observation							
46.	**Total**				**5,293,778**	**3,655,869**	**1,785,333**	**1,527,671**

* 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:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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)	52,649,424			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	30,362			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,734.06			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	421			
3.	Program general inpatient routine cost (Line 1c X Line 2)	730,039			
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)	730,039			

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	61,106,490	35,743	1,709.61	428	731,713
9.	Coronary Care Unit					
10.	HOT Unit	11,982,449	5,870	2,041.30	109	222,502
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)					1,785,333
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**3,469,587**

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:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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.	HOT Unit						
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 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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.	Psychiatry							
23.	Transport							
24.	Dental							
25.	GI Services							
26.	Genetics							
27.	Child Development							
28.	Child Protection Center							
29.	Home Program Dialysis							
30.	Kidney Acquisition							
31.	Heart Acquisition							
32.	Liver Acquisition							
33.	CT Scan							
34.	MRI							
35.	Cardiac Cath							
36.	Implant Dev. Charged							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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.	HOT Unit							
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)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		1,527,671
2.	Inpatient Operating Services (BHF Page 4, Line 25)	3,469,587	
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)	177,730	43,940
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**3,647,317**	**1,571,611**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	70.00%	30.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	5,293,778	3,655,869
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	765,993	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,317,319	
	F. Coronary Care Unit		
	G. HOT Unit	351,342	
	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)**	8,728,432	3,655,869
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		7,165,373
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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)	3,647,317	1,571,611
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,647,317	1,571,611
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)**	**3,647,317**	**1,571,611**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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)	7,165,373
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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
52-3300	**13029**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2013 To: 12/31/2013**

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)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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	636,516	35,112,275	0.018128	358,813	166,939	6,505	3,026
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	475,454	12,662,000	0.037550	67,342	68,553	2,529	2,574
5.	Radiology - Diagnostic	680,029	41,177,248	0.016515	247,108	180,554	4,081	2,982
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	67,978	109,102,114	0.000623	921,827	1,172,895	574	731
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	616,629	40,494,579	0.015227	251,783	105,615	3,834	1,608
13.	Physical Therapy	350,327	11,839,447	0.029590	69,194	3,065	2,047	91
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	448,529	5,962,788	0.075221	60,023	19,010	4,515	1,430
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	190,940	4,338,555	0.044010				
21.	Ambulance							
22.	Psychiatry	370,952	2,720,550	0.136352				
23.	Transport	227,317	5,573,782	0.040783	77,401		3,157	
24.	Dental	795,559	7,932,870	0.100286				
25.	GI Services	683,131	2,333,449	0.292756		4,793		1,403
26.	Genetics	135,366	844,136	0.160360		3,466		556
27.	Child Development	186,904	334,384	0.558950		422		236
28.	Child Protection Center	107,407	1,199,293	0.089559				
29.	Home Program Dialysis							
30.	Kidney Acquisition	115,036	808,391	0.142302				
31.	Heart Acquisition							
32.	Liver Acquisition							
33.	CT Scan							
34.	MRI							
35.	Cardiac Cath							
36.	Implant Dev. Charged							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	2,674,341	33,754,216	0.079230	4,799	343,736	380	27,234
44.	Emergency	1,292,622	22,312,799	0.057932	26,876	35,716	1,557	2,069
45.	Observation							
46.	**Ancillary Total**						**29,179**	**43,940**

* 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:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

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	7,031,356	30,362	231.58	421		97,495	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,508,688	35,743	98.16	428		42,012	
52.	Coronary Care Unit							
53.	HOT Unit	487,022	5,870	82.97	109		9,044	
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)**						**148,551**	
68.	**Ancillary Total (from line 46)**						**29,179**	**43,940**
69.	**Total (Lines 67-68)**						**177,730**	**43,940**

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-3300	13029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2013 To: 12/31/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	958		958
Newborn Days			
Total Inpatient Revenue	8,728,432		8,728,432
Ancillary Revenue	5,293,778		5,293,778
Routine Revenue	3,434,654		3,434,654
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue	3,655,869		3,655,869
Outpatient Received and Receivable			

Notes:

Clinic costs and charges on BHF Page 3 include data from W/S C, lines 90.01, 90.08-90.27.