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:** 01/01/2014	**To:** 12/31/2014	

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 01/01/2014 and ending 12/31/2014 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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: 01/01/2014 To: 12/31/2014

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		28,319	49.42%		11,380	6.27
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	116	42,340		36,758	86.82%			
6.	Coronary Care Unit								
7.	HOT Unit	24	8,760		6,248	71.32%			
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**	**297**	**108,405**		**71,325**	**65.79%**		**11,380**	**6.27**
23.	Observation Bed Days								

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				233			100	5.75
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				185				
6.	Coronary Care Unit								
7.	HOT Unit				157				
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**				**575**	**0.81%**		**100**	**5.75**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	2,238	282,804

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: 01/01/2014 To: 12/31/2014

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	25,678,669	34,431,970	0.745780	224,075	83,166	167,111	62,024
2.	Recovery Room	3,549,365	13,563,322	0.261688	24,917	95,590	6,520	25,015
3.	Delivery and Labor Room							
4.	Anesthesiology	2,034,985	11,943,135	0.170390	30,899	48,126	5,265	8,200
5.	Radiology - Diagnostic	22,305,954	41,806,447	0.533553	105,913	118,516	56,510	63,235
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	931,702	1,592,848	0.584928		15,436		9,029
8.	Laboratory	32,355,753	109,004,974	0.296828	826,402	1,040,094	245,299	308,729
9.	Blood							
10.	Blood - Administration	5,460,811	9,154,274	0.596531	68,860	18,970	41,077	11,316
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,053,977	40,559,596	0.247882	223,438	69,120	55,386	17,134
13.	Physical Therapy	6,306,801	12,114,352	0.520606	29,778	2,392	15,503	1,245
14.	Occupational Therapy							
15.	Speech Pathology	5,093,339	7,103,080	0.717061	6,163	23,363	4,419	16,753
16.	EKG	8,774,598	13,036,528	0.673078	66,936	135,095	45,053	90,929
17.	EEG	1,974,893	7,528,050	0.262338	46,547	5,218	12,211	1,369
18.	Med. / Surg. Supplies	21,208,076	123,386,840	0.171883	1,119,644	296,343	192,448	50,936
19.	Drugs Charged to Patients	44,565,906	126,458,061	0.352416	1,136,821	401,852	400,634	141,619
20.	Renal Dialysis	1,155,107	3,976,281	0.290499		10,806		3,139
21.	Ambulance							
22.	Psychiatry	3,084,790	2,565,611	1.202361				
23.	Transport	6,212,972	5,407,389	1.148978	92,763	35,411	106,583	40,686
24.	Dental	5,013,098	8,348,541	0.600476				
25.	GI Services	3,986,303	2,148,889	1.855053		9,782		18,146
26.	Genetics	1,904,591	649,609	2.931904		4,617		13,537
27.	Child Development	931,620	237,991	3.914518				
28.	Child Protection Center	2,560,245	1,187,293	2.156372				
29.	Home Program Dialysis	349,251	276,460	1.263297				
30.	Kidney Acquisition	618,203	353,836	1.747146				
31.	Heart Acquisition	482,652	1,091,016	0.442388				
32.	Liver Acquisition	1,527,885	542,832	2.814655				
33.	CT Scan	1,395,503	9,857,117	0.141573	44,458	73,904	6,294	10,463
34.	MRI	2,460,407	21,369,551	0.115136	52,841	171,458	6,084	19,741
35.	Cardiac Cath	3,332,638	7,607,005	0.438101	63,445	70,475	27,795	30,875
36.	Implant Dev. Charged	18,635,124	8,955,196	2.080929				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	43,283,639	31,145,603	1.389719	92,711	416,090	128,842	578,248
44.	Emergency	13,667,357	24,803,189	0.551032	21,251	43,761	11,710	24,114
45.	Observation							
46.	**Total**				**4,277,862**	**3,189,585**	**1,534,744**	**1,546,482**

* 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: 01/01/2014 To: 12/31/2014

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)	54,771,489			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	28,319			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,934.09			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	233			
3.	Program general inpatient routine cost (Line 1c X Line 2)	450,643			
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)	450,643			

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	65,460,809	36,758	1,780.86	185	329,459
9.	Coronary Care Unit					
10.	HOT Unit	12,762,969	6,248	2,042.73	157	320,709
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)					1,534,744
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,635,555**

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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		1,546,482
2.	Inpatient Operating Services (BHF Page 4, Line 25)	2,635,555	
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)	146,107	102,066
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,781,662**	**1,648,548**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	63.00%	37.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	4,277,862	3,189,585
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	607,380	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	985,629	
	F. Coronary Care Unit		
	G. HOT Unit	610,758	
	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)**	6,481,629	3,189,585
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,241,004
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: 01/01/2014 To: 12/31/2014

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)	2,781,662	1,648,548
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,781,662	1,648,548
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)**	**2,781,662**	**1,648,548**

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: 01/01/2014 To: 12/31/2014

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)	5,241,004
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)	(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

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
52-3300	**13029**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2014 To: 12/31/2014**

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: 01/01/2014 To: 12/31/2014

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	881,553	34,431,970	0.025603	224,075	83,166	5,737	2,129
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	958,820	11,943,135	0.080282	30,899	48,126	2,481	3,864
5.	Radiology - Diagnostic	410,408	41,806,447	0.009817	105,913	118,516	1,040	1,163
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	63,208	109,004,974	0.000580	826,402	1,040,094	479	603
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	144,339	12,114,352	0.011915	29,778	2,392	355	29
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	581,727	7,528,050	0.077275	46,547	5,218	3,597	403
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	226,931	3,976,281	0.057071		10,806		617
21.	Ambulance							
22.	Psychiatry	560,827	2,565,611	0.218594				
23.	Transport							
24.	Dental	1,013,035	8,348,541	0.121343				
25.	GI Services	1,086,123	2,148,889	0.505435		9,782		4,944
26.	Genetics	195,894	649,609	0.301557		4,617		1,392
27.	Child Development	406,671	237,991	1.708766				
28.	Child Protection Center	263,599	1,187,293	0.222017				
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 Centers							
43.	Clinic	6,234,011	31,145,603	0.200157	92,711	416,090	18,557	83,283
44.	Emergency	2,062,360	24,803,189	0.083149	21,251	43,761	1,767	3,639
45.	Observation							
46.	**Ancillary Total**						**34,013**	**102,066**

* 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: 01/01/2014 To: 12/31/2014

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	8,643,059	28,319	305.20	233		71,112	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,308,465	36,758	90.01	185		16,652	
52.	Coronary Care Unit							
53.	HOT Unit	968,257	6,248	154.97	157		24,330	
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)**						**112,094**	
68.	**Ancillary Total (from line 46)**						**34,013**	**102,066**
69.	**Total (Lines 67-68)**						**146,107**	**102,066**

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: 01/01/2014 To: 12/31/2014**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	575		575
Newborn Days			
Total Inpatient Revenue	6,481,629		6,481,629
Ancillary Revenue	4,277,862		4,277,862
Routine Revenue	2,203,767		2,203,767
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	2,238		2,238
Total Outpatient Revenue	3,189,585		3,189,585
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.