

# 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: University of Chicago - Comer Children's Hospital		Medicare Provider Number: 14-0088
Street: 5841 South Maryland Avenue		Medicaid Provider Number: 3466
City: Chicago	State: Illinois	Zip: 60637-1424
Period Covered by Statement:	From: 07/01/2018	To: 06/30/2019

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

**Type of Hospital**

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

**Health Care Program**

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

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> _____
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> _____

**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 - Comer 3466 for the cost report beginning 07/01/2018 and ending 06/30/2019 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

\_\_\_\_\_  
 Name (Typewritten)  
 Title \_\_\_\_\_ Date \_\_\_\_\_  
 Firm \_\_\_\_\_  
 Telephone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_

\_\_\_\_\_  
 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: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

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
<b>Part I-Hospital</b>									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	60	21,900		20,490	93.56%		5,240	8.28
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	19	6,935		4,679	67.47%			
6.	Coronary Care Unit	9	3,285		2,133	64.93%			
7.	Burn ICU								
8.	Nursery Special Care								
9.	Nursery ICU	53	19,345		16,076	83.10%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
<b>22.</b>	<b>Total</b>	<b>141</b>	<b>51,465</b>		<b>43,378</b>	<b>84.29%</b>		<b>5,240</b>	<b>8.28</b>
23.	Observation Bed Days				3,280				

<b>Part II-Program</b>		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,500			2,257	6.77
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,095				
6.	Coronary Care Unit								
7.	Burn ICU				168				
8.	Nursery Special Care								
9.	Nursery ICU				9,522				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
<b>22.</b>	<b>Total</b>				<b>15,285</b>	<b>35.24%</b>		<b>2,257</b>	<b>6.77</b>

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

<b>Medicare Provider Number:</b> 14-0088	<b>Medicaid Provider Number:</b> 3466
<b>Program:</b> Medicaid Hospital	<b>Period Covered by Statement:</b> From: 07/01/2018 To: 06/30/2019

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	90,582,753	599,593,748	0.151074	12,585,510		1,901,343	
2.	Recovery Room	30,192,229	91,801,113	0.328887				
3.	Delivery and Labor Room	13,088,422	33,090,647	0.395532				
4.	Anesthesiology	13,465,013	258,426,089	0.052104	3,167,652		165,047	
5.	Radiology - Diagnostic	40,091,376	257,401,270	0.155754	2,845,009		443,122	
6.	Radiology - Therapeutic	18,619,267	176,910,850	0.105247				
7.	Nuclear Medicine		54,802,667					
8.	Laboratory	70,922,618	989,667,180	0.071663	15,792,738		1,131,755	
9.	Blood							
10.	Blood - Administration	21,748,481	143,231,806	0.151841	3,220,151		488,951	
11.	Intravenous Therapy							
12.	Respiratory Therapy	23,031,378	152,115,003	0.151408	21,678,811		3,282,345	
13.	Physical Therapy	12,682,955	49,220,000	0.257679	1,083,408		279,171	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	20,988,397	248,157,246	0.084577	3,072,760		259,885	
17.	EEG	7,161,306	44,851,084	0.159669	1,503,750		240,102	
18.	Med. / Surg. Supplies	45,557,520	190,117,777	0.239628				
19.	Drugs Charged to Patients	204,088,779	#####	0.139656				
20.	Renal Dialysis	7,474,726	38,847,632	0.192411	642,091		123,545	
21.	Ambulance	1,474,943	7,536	195.719613	3,930		769,178	
22.	CT Scan	10,768,581	449,578,580	0.023953	1,504,051		36,027	
23.	MRI	9,937,605	163,088,620	0.060934	1,127,074		68,677	
24.	Cardiac Cath	8,978,165	110,223,232	0.081454	423,656		34,508	
25.	Brace & Plaster Room	370,200	836,669	0.442469				
26.	Implants	68,895,418	295,689,880	0.232999				
27.	Cardiac Rehab	245,299	2,024,171	0.121185				
28.	Kidney Acquisition	7,072,171	9,357,626	0.755766				
29.	Heart Acquisition	3,663,602	6,628,860	0.552675				
30.	Liver Acquisition	3,662,352	6,609,125	0.554136				
31.	Lung Acquisition	2,844,160	3,480,484	0.817174				
32.	Pancreas Acquisition	901,825	738,760	1.220728				
33.	All Other Clinics	71,124						
34.	Other	2,064,724	29,670,015	0.069590				
35.	Other	11,376,716	5,001,854	2.274500				
36.	Other	2,103,762						
37.	Other	359,431						
38.	Other							
39.	Other							
40.	Other							
41.	Other	48,225,085	239,246,302	0.201571				
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	158,565,913	547,795,731	0.289462	1,812,553		524,665	
44.	Emergency	51,034,157	382,831,679	0.133307				
45.	Observation	24,726,708	100,502,588	0.246031				
46.	<b>Total</b>				<b>70,463,144</b>		<b>9,748,321</b>	

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	35,943,890			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	23,770			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,512.15			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,500			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,292,525			
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)	5,292,525			

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	13,048,790	4,679	2,788.80	2,095	5,842,536
9.	Coronary Care Unit	4,702,926	2,133	2,204.84		
10.	Burn ICU				168	
11.	Nursery Special Care					
12.	Nursery ICU	33,863,648	16,076	2,106.47	9,522	20,057,807
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)					9,748,321
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>40,941,189</b>

**Hospital Statement of Cost Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	<b>Total (Sum of Lines 22 and 26)</b>								

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

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

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)
	<b>Inpatient Ancillary Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
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.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	All Other Clinics							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>							

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

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

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>							
69.	<b>Total (Lines 67-68)</b>							

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

Preliminary

<b>Medicare Provider Number:</b> 14-0088		<b>Medicaid Provider Number:</b> 3466	
<b>Program:</b> Medicaid Hospital		<b>Period Covered by Statement:</b> From: 07/01/2018 To: 06/30/2019	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	40,941,189	
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)	3,041,181	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>43,982,370</b>	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	70,463,144	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	14,259,877	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	19,948,742	
	F. Coronary Care Unit		
	G. Burn ICU	986,550	
	H. Nursery Special Care		
	I. Nursery ICU	67,166,494	
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>172,824,807</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		128,842,437
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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	43,982,370	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	43,982,370	
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>43,982,370</b>	

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

\* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

**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)	128,842,437
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
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) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			1.	Cost Report Period ended		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	<b>Total (Sum of Lines 1 - 3)</b>					

**Hospital Statement of Cost  
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

**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: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

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)
	<b>Inpatient Ancillary Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
1.	Operating Room	9,313,771	599,593,748	0.015533	12,585,510		195,491	
2.	Recovery Room							
3.	Delivery and Labor Room	2,940,900	33,090,647	0.088874				
4.	Anesthesiology	6,223,895	258,426,089	0.024084	3,167,652		76,290	
5.	Radiology - Diagnostic	3,895,451	257,401,270	0.015134	2,845,009		43,056	
6.	Radiology - Therapeutic	921,445	176,910,850	0.005209				
7.	Nuclear Medicine							
8.	Laboratory	5,103,814	989,667,180	0.005157	15,792,738		81,443	
9.	Blood							
10.	Blood - Administration	33,106	143,231,806	0.000231	3,220,151		744	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	480,034	248,157,246	0.001934	3,072,760		5,943	
17.	EEG	684,187	44,851,084	0.015255	1,503,750		22,940	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	110,352	38,847,632	0.002841	642,091		1,824	
21.	Ambulance							
22.	CT Scan	551,763	449,578,580	0.001227	1,504,051		1,845	
23.	MRI	115,870	163,088,620	0.000710	1,127,074		800	
24.	Cardiac Cath	584,869	110,223,232	0.005306	423,656		2,248	
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	All Other Clinics	292,435		#DIV/0!				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic	8,651,655	547,795,731	0.015794	1,812,553		28,627	
44.	Emergency	2,703,643	382,831,679	0.007062				
45.	Observation							
46.	<b>Ancillary Total</b>						<b>461,251</b>	

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2018</b> To: <b>06/30/2019</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics	3,794,927	23,770	159.65	3,500		558,775	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,003,174	4,679	214.40	2,095		449,168	
52.	Coronary Care Unit	299,714	2,133	140.51				
53.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU	2,653,983	16,076	165.09	9,522		1,571,987	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	<b>Routine Total (lines 47-66)</b>						<b>2,579,930</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>461,251</b>	
69.	<b>Total (Lines 67-68)</b>						<b>3,041,181</b>	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	15,285		15,285
Newborn Days			
Total Inpatient Revenue	172,824,805	2	172,824,807
Ancillary Revenue	70,463,143	1	70,463,144
Routine Revenue	102,361,662	1	102,361,663
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

- BHF Page 2 - A&P Total Inpatient Days adjusted to agree with W/S S-3 and allocated between Acute & Children's per attached worksheet
- BHF Page 2 - Newborn Nursery Days adjusted to agree with W/S S-3 and allocated between Acute & Children's per attached worksheet
- BHF Page 3 - Total Costs and Charges adjusted to W/S C columns 1 & 8
- BHF Page 3 - General I/P Routine Service Costs, ICU Costs, Coronary Care Costs, Burn ICU Costs, & Nursery Costs allocated between Acute & Children's per attached worksheet
- BHF Page 3 - GME Costs for A&P, ICU, Coronary Care, Burn ICU, Nursery ICU and Nursery allocated between Acute and Children's per attached worksheet
- Minor adjustments due to rounding