

Hospital Statement of Cost

BHF Page 1

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 Illinois		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Ave		Medicaid Provider Number: 16008
City: Peoria	State: Illinois	Zip: 61637
Period Covered by Statement:	From: 10/01/2009	To: 09/30/2010

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☒ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) Children's Hospital

Health Care Program

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

☒ Medicaid Hospital	☐ Medicaid Sub II	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I	☐ Medicaid Sub III	☐ U of I - Division of Specialized Care for Children

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable
By Fine And / Or Imprisonment Under Federal Law**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/2009 and ending 09/30/2010 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Name (Typewritten)

Title

Date

Firm

Telephone Number

Name (Typewritten)

Title

Date

Telephone Number

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	76	27,740		14,981	54.01%		3,761	7.86
2.	Rehab Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	12	4,380		3,565	81.39%			
6.	Coronary Care Unit								
7.	Premature Intensive Care	38	13,870		11,000	79.31%			
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	126	45,990		29,546	64.24%		3,761	7.86
23.	Observation Bed Days				544				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics			636	14,068			3,088	6.15
2.	Rehab Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				1,977				
6.	Coronary Care Unit								
7.	Premature Intensive Care				2,936				
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			636	18,981	64.24%		3,088	6.15

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0067		16008	
Program:		Period Covered by Statement:	
Medicaid-Hospital [Children's]		From: 10/01/2009	To: 09/30/2010

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	38,858,511	142,234,870	0.273200	6,900,982		1,885,348	
2.	Recovery Room	3,852,144	27,419,541	0.140489	1,138,860		159,997	
3.	Delivery and Labor Room	8,684,053	10,655,249	0.815002				
4.	Anesthesiology	3,576,254	93,019,681	0.038446	5,060,375		194,551	
5.	Radiology - Diagnostic	64,509,645	465,139,383	0.138689	8,669,941		1,202,425	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	36,141,381	310,304,967	0.116471	13,353,975		1,555,351	
9.	Blood							
10.	Blood - Administration	8,113,247	14,339,278	0.565806	1,112,624		629,529	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,072,625	72,652,018	0.138642	11,757,591		1,630,096	
13.	Physical Therapy	14,380,203	39,967,332	0.359799	407,513		146,623	
14.	Occupational Therapy							
15.	Speech Pathology	1,297,379	3,505,553	0.370093	217,621		80,540	
16.	EKG	5,173,876	48,129,540	0.107499	750,835		80,714	
17.	EEG	1,106,840	6,555,924	0.168831	1,618,824		273,308	
18.	Med. / Surg. Supplies	34,566,763	231,636,474	0.149228	12,641,501		1,886,466	
19.	Drugs Charged to Patients	36,274,958	209,938,493	0.172789	20,611,649		3,561,466	
20.	Renal Dialysis	2,032,135	5,724,251	0.355005	150,929		53,581	
21.	Ambulance	9,900,983	23,360,965	0.423826	2,536,410		1,074,997	
22.	Implants Device	43,592,957	137,740,878	0.316485	2,124,605		672,406	
23.	Digestive Diseases	4,694,980	39,048,770	0.120234	149,187		17,937	
24.	Cardiac Cath Lab	6,303,313	68,024,197	0.092663	568,998		52,725	
25.	Special Clinics	621,239	1,750,059	0.354982	20,132		7,146	
26.	Sisters Clinic	4,693,549	3,782,919	1.240722	735		912	
27.	Diabetes Clinic	843,815	141,268	5.973150				
28.	Wound Care	1,412,332	4,454,471	0.317059				
29.	Psychology	468,339	612,661	0.764434				
30.	Neuro Diagnostic	1,145,810	2,112,359	0.542431	6,175		3,350	
31.	Urological	133,347	641,102	0.207997	964		201	
32.	Lithotripsy	209,850	1,199,698	0.174919				
33.	Sleep Disorders	3,754,864	15,310,635	0.245245	243		60	
34.	Pain Program	1,901,513	3,961,784	0.479964				
35.	Comp Epilepsy	890,018	5,519,832	0.161240	7,375		1,189	
36.	Kidney Acquisition	3,912,520	4,023,807	0.972343				
37.	Pancreas Acquisition	317,576	317,576	1.000000				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	25,668,296	97,617,202	0.262948	2,094,015		550,617	
45.	Observation-Distinct Part	1,914,493	2,336,561	0.819364	63,330		51,890	
46.	Total				91,965,389		15,773,425	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehab Unit	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	14,209,814			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	15,525			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	915.29			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	14,068			
3.	Program general inpatient routine cost (Line 1c X Line 2)	12,876,300			
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)	636			
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)	12,876,300			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	6,115,401	3,565	1,715.40	1,977	3,391,346
9.	Coronary Care Unit					
10.	Premature Intensive Care	16,411,998	11,000	1,492.00	2,936	4,380,512
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)					15,773,425
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					36,421,583

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

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Rehab Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Premature Intensive Care						
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 Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation-Distinct Part								
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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room	116,541	10,655,249	0.010937				
4.	Anesthesiology	35,751	93,019,681	0.000384	5,060,375		1,943	
5.	Radiology - Diagnostic	1,950,959	465,139,383	0.004194	8,669,941		36,362	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,884	72,652,018	0.000081	11,757,591		952	
13.	Physical Therapy	560,610	39,967,332	0.014027	407,513		5,716	
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.	Implants Device							
23.	Digestive Diseases							
24.	Cardiac Cath Lab							
25.	Special Clinics	238,426	1,750,059	0.136239	20,132		2,743	
26.	Sisters Clinic	5,925	3,782,919	0.001566	735		1	
27.	Diabetes Clinic							
28.	Wound Care							
29.	Psychology							
30.	Neuro Diagnostic	340,543	2,112,359	0.161215	6,175		996	
31.	Urological							
32.	Lithotripsy							
33.	Sleep Disorders	1,002,210	15,310,635	0.065458	243		16	
34.	Pain Program	397,079	3,961,784	0.100227				
35.	Comp Epilepsy	554,160	5,519,832	0.100394	7,375		740	
36.	Kidney Acquisition							
37.	Pancreas Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	5,043,677	97,617,202	0.051668	2,094,015		108,194	
45.	Observation-Distinct Part							
46.	Ancillary Total						157,663	

* 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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	81,922	15,525	5.28	14,068		74,279	
48.	Rehab Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	4,023	3,565	1.13	1,977		2,234	
52.	Coronary Care Unit							
53.	Premature Intensive Care	167,494	11,000	15.23	2,936		44,715	
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)						121,228	
68.	Ancillary Total (from line 46)						157,663	
69.	Total (Lines 67-68)						278,891	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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)		36,421,583	
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)		278,891	
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)		3,098,721	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		39,799,195	
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)		91,965,389	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		22,522,296	
B. Rehab Unit			
C. Sub II			
D. Sub III			
E. Intensive Care Unit		6,661,446	
F. Coronary Care Unit			
G. Premature Intensive Care		9,274,195	
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)		130,423,326	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			90,624,131
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

BHF Page 8

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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)	39,799,195	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	39,799,195	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	39,799,195	

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.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	90,624,131
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(2A)		(3A)	
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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

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

Part C. Program Cost

	General Service	Sub I Rehab Unit	Sub II Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	6,326,944	142,234,870	0.044482	6,900,982		306,969	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	527,072	93,019,681	0.005666	5,060,375		28,672	
5.	Radiology - Diagnostic	5,833,810	465,139,383	0.012542	8,669,941		108,738	
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	145,169	6,555,924	0.022143	1,618,824		35,846	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants Device							
23.	Digestive Diseases							
24.	Cardiac Cath Lab							
25.	Special Clinics							
26.	Sisters Clinic	2,035,565	3,782,919	0.538094	735		395	
27.	Diabetes Clinic							
28.	Wound Care							
29.	Psychology							
30.	Neuro Diagnostic							
31.	Urological							
32.	Lithotripsy							
33.	Sleep Disorders							
34.	Pain Program							
35.	Comp Epilepsy							
36.	Kidney Acquisition							
37.	Pancreas Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	6,123,596	97,617,202	0.062731	2,094,015		131,360	
45.	Observation-Distinct Part							
46.	Ancillary Total						611,980	

* 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:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,997,468	15,525	128.66	14,068		1,809,989	
48.	Rehab Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	692,612	3,565	194.28	1,977		384,092	
52.	Coronary Care Unit							
53.	Premature Intensive Care	1,096,532	11,000	99.68	2,936		292,660	
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)						2,486,741	
68.	Ancillary Total (from line 46)						611,980	
69.	Total (Lines 67-68)						3,098,721	

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	18,981		18,981
Newborn Days			
Total Inpatient Revenue	130,423,326		130,423,326
Ancillary Revenue	91,965,389		91,965,389
Routine Revenue	38,457,937		38,457,937
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Spread between Acute & Children's Hospital.

BHF Pg3 Charges for Radiology-Diagnostic, Physical Therapy, EEG, Special Clinics, Sister's Clinic, Neuro Diagnostic, Sleep Disorders, Pain Program, Comp Epilepsy, Kidney Acquisition, ER, and Observation are greater than filed W/S C, Pt 1, Col 8.

Pancreas Acquisition Charges were adjusted to filed W/S D-6, Pt III & IV, Line 51.