

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: University of Chicago - Children's Hospital		Medicare Provider Number: 14-0088
Street: 5841 South Maryland Avenue		Medicaid Provider Number: 3466
City: Chicago	State: Illinois	Zip: 60637
Period Covered by Statement:	From: 07/01/2009	To: 06/30/2010

Type of Control

Voluntary Nonprofit

☐

Church

☐
XXXX
XXXX

Corporation

☐

Other (Specify)

Proprietary

☐

Individual

☐

Partnership

☐

Corporation

Government (Non-Federal)

☐

State

☐

City

☐

County

☐

Township

☐

Hospital District

☐

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

☐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)) University of Chicago - Children's Hospital 3466 for the cost report beginning 07/01/2009 and ending 06/30/2010 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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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	60	21,900		15,495	70.75%		4,889	9.03
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	20	7,300		5,347	73.25%			
6.	Coronary Care Unit	10	3,650		1,874	51.34%			
7.	Burn ICU	2	730		662	90.68%			
8.	Nursery Special Care	24	8,760		6,428	73.38%			
9.	Nursery ICU	47	17,155		14,336	83.57%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,935		401	5.78%			
22.	Total	182	66,430		44,543	67.05%		4,889	9.03
23.	Observation Bed Days				584				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				11,756			2,902	9.46
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				1,343				
6.	Coronary Care Unit								
7.	Burn ICU				444				
8.	Nursery Special Care				4,574				
9.	Nursery ICU				9,330				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				347				
22.	Total				27,794	62.40%		2,902	9.46

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:	
14-0088		3466	
Program:		Period Covered by Statement:	
Medicaid-Hospital [Children's]		From: 07/01/2009	To: 06/30/2010

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	64,112,874	259,436,875	0.247123	17,090,398		4,223,430	
2.	Recovery Room							
3.	Delivery and Labor Room	8,382,700	18,231,777	0.459785				
4.	Anesthesiology	8,055,186	85,616,300	0.094085	5,293,902		498,077	
5.	Radiology - Diagnostic	51,507,225	296,607,460	0.173655	8,684,505		1,508,108	
6.	Radiology - Therapeutic	11,569,479	63,808,224	0.181316	162,473		29,459	
7.	Nuclear Medicine							
8.	Laboratory	52,788,786	340,562,728	0.155005	16,022,357		2,483,545	
9.	Blood							
10.	Blood - Administration	16,159,247	95,520,973	0.169170	7,442,379		1,259,027	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,508,543	137,423,101	0.120129	50,013,519		6,008,074	
13.	Physical Therapy	7,485,891	19,782,040	0.378419	1,159,468		438,765	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	20,544,380	128,568,236	0.159794	2,121,652		339,027	
17.	EEG	4,181,857	10,529,174	0.397169	1,024,677		406,970	
18.	Med. / Surg. Supplies	12,723,955	40,568,092	0.313644	915,514		287,145	
19.	Drugs Charged to Patients	70,648,035	446,984,169	0.158055	31,939,781		5,048,242	
20.	Renal Dialysis	21,503,540	157,492,273	0.136537	931,653		127,205	
21.	Ambulance	3,707,343	4,572,688	0.810758	7,137		5,786	
22.	Brace & Plaster Room	219,861	558,533	0.393640	4,569		1,799	
23.	Kidney Acquisition [per W/S D-6]	3,750,922	4,276,641	0.877072				
24.	Liver Acquisition [per W/S D-6]	2,049,915	1,428,105	1.435409	164,158		235,634	
25.	Heart Acquisition [per W/S D-6]	1,583,106	1,854,605	0.853608				
26.	Pancreas Acquisition [per W/S D-6]	468,469	777,743	0.602344				
27.	Implants Charged to Patients	33,586,931	114,563,876	0.293172	4,024,108		1,179,756	
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	93,344,727	172,795,803	0.540203	4,319,618		2,333,471	
44.	Emergency	26,944,530	176,233,328	0.152891				
45.	Observation	4,329,355	7,660,695	0.565139				
46.	Total				151,321,868		26,413,520	

* 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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Sub I	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)	19,997,618			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	16,079			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,243.71			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	11,756			
3.	Program general inpatient routine cost (Line 1c X Line 2)	14,621,055			
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)	14,621,055			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1) (A)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	8,108,613	5,347	1,516.48	1,343	2,036,633
9.	Coronary Care Unit	2,826,508	1,874	1,508.28		
10.	Burn ICU	1,062,452	662	1,604.91	444	712,580
11.	Nursery Special Care	4,856,085	6,428	755.46	4,574	3,455,474
12.	Nursery ICU	23,857,642	14,336	1,664.18	9,330	15,526,799
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	155,448	401	387.65	347	134,515
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					26,413,520
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					62,900,576

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 [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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.	Sub I						
4.	Sub II						
5.	Sub III						
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, 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								
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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Brace & Plaster Room							
23.	Kidney Acquisition [per W/S D-6]							
24.	Liver Acquisition [per W/S D-6]							
25.	Heart Acquisition [per W/S D-6]							
26.	Pancreas Acquisition [per W/S D-6]							
27.	Implants Charged to Patients							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

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

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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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							
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

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)		62,900,576	
3. Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)			
4. Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)			
5. Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)			
6. Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)		6,715,131	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		69,615,707	
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)		151,321,868	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		50,552,170	
B. Sub I			
C. Sub II			
D. Sub III			
E. Intensive Care Unit		5,957,814	
F. Coronary Care Unit			
G. Burn ICU		2,568,141	
H. Nursery Special Care		12,145,206	
I. Nursery ICU		43,700,261	
J. Other			
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		629,340	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		266,874,800	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			197,259,093
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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

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)	69,615,707	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	69,615,707	
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)	69,615,707	

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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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)	197,259,093
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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

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 Sub I	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 Sub I	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 Sub I	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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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	3,305,284	259,436,875	0.012740	17,090,398		217,732	
2.	Recovery Room							
3.	Delivery and Labor Room	1,249,897	18,231,777	0.068556				
4.	Anesthesiology	935,108	85,616,300	0.010922	5,293,902		57,820	
5.	Radiology - Diagnostic	3,036,787	296,607,460	0.010238	8,684,505		88,912	
6.	Radiology - Therapeutic	833,264	63,808,224	0.013059	162,473		2,122	
7.	Nuclear Medicine							
8.	Laboratory	2,897,910	340,562,728	0.008509	16,022,357		136,334	
9.	Blood							
10.	Blood - Administration	259,238	95,520,973	0.002714	7,442,379		20,199	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	231,463	128,568,236	0.001800	2,121,652		3,819	
17.	EEG	888,816	10,529,174	0.084415	1,024,677		86,498	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	2,087,072	157,492,273	0.013252	931,653		12,346	
21.	Ambulance							
22.	Brace & Plaster Room							
23.	Kidney Acquisition [per W/S D-6]							
24.	Liver Acquisition [per W/S D-6]							
25.	Heart Acquisition [per W/S D-6]							
26.	Pancreas Acquisition [per W/S D-6]							
27.	Implants Charged to Patients							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	12,980,413	172,795,803	0.075120	4,319,618		324,490	
44.	Emergency	4,407,045	176,233,328	0.025007				
45.	Observation							
46.	Ancillary Total						950,272	

* 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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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	5,594,976	16,079	347.97	11,756		4,090,735	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	741,546	5,347	138.68	1,343		186,247	
52.	Coronary Care Unit	108,078	1,874	57.67				
53.	Burn ICU	13,999	662	21.15	444		9,391	
54.	Nursery Special Care	444,408	6,428	69.14	4,574		316,246	
55.	Nursery ICU	1,675,788	14,336	116.89	9,330		1,090,584	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	82,805	401	206.50	347		71,656	
67.	Routine Total (lines 47-66)						5,764,859	
68.	Ancillary Total (from line 46)						950,272	
69.	Total (Lines 67-68)						6,715,131	

PRELIMINARY

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	27,447		27,447
Newborn Days	347		347
Total Inpatient Revenue	266,874,800		266,874,800
Ancillary Revenue	151,321,868		151,321,868
Routine Revenue	115,552,932		115,552,932
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Spread between Actue & Children's Hospital.

Observation Bed Days were taken from filed S-3 & spread between Actue & Children's Hospital.

BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.

Costs for Kidney/Liver/Heart/Pancreas Acquisition were adjusted to filed W/S B, Pt 1, Col 25.

Charges for Kidney/Liver/Heart Acquisition are greater than filed W/S D-6, Pt III & IV, Line 51.

Renal Dialysis Charges are greater than filed W/S C, Pt 1, Col 8.

GME Costs were adjusted to filed W/S B, Pt 1, Col 26.