

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-Revised

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: 60637-1424	
Period Covered by Statement:	From: 07/01/2011	To: 06/30/2012	

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)) University of Chicago- Childre 3466 for the cost report beginning 07/01/2011 and ending 06/30/2012 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

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

BHF Page 2

Preliminary-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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	21,960		13,955	63.55%		4,705	8.37
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,320		4,930	67.35%			
6.	Coronary Care Unit	10	3,660		1,552	42.40%			
7.	Burn ICU	2	732		662	90.44%			
8.	Nursery Special Care	24	8,784		4,470	50.89%			
9.	Nursery ICU	47	17,202		13,790	80.17%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,954		1,431	20.58%			
22.	Total	182	66,612		40,790	61.24%		4,705	8.37
23.	Observation Bed Days				371				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,498			2,598	8.61
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,008				
6.	Coronary Care Unit				10				
7.	Burn ICU				210				
8.	Nursery Special Care				2,992				
9.	Nursery ICU				9,652				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				609				
22.	Total				22,979	56.33%		2,598	8.61

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-Revised

Medicare Provider Number:		Medicaid Provider Number:	
14-0088		3466	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2011	To: 06/30/2012

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	78,807,922	325,012,766	0.242476	14,133,937		3,427,141	
2.	Recovery Room							
3.	Delivery and Labor Room	8,959,512	16,413,166	0.545873				
4.	Anesthesiology	8,731,757	104,921,704	0.083222	4,331,254		360,456	
5.	Radiology - Diagnostic	39,470,325	151,946,789	0.259764	5,245,362		1,362,556	
6.	Radiology - Therapeutic	12,711,276	83,138,188	0.152893	57,544		8,798	
7.	Nuclear Medicine							
8.	Laboratory	50,545,171	354,649,047	0.142522	12,866,044		1,833,694	
9.	Blood							
10.	Blood - Administration	18,055,093	100,820,599	0.179081	7,017,404		1,256,684	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,795,069	143,963,653	0.116662	43,119,750		5,030,436	
13.	Physical Therapy	9,238,985	27,678,701	0.333794	1,215,063		405,581	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	14,597,117	113,335,133	0.128796	2,039,284		262,652	
17.	EEG	5,299,627	14,157,972	0.374321	1,299,543		486,446	
18.	Med. / Surg. Supplies	17,731,208	61,600,614	0.287841	1,037,183		298,544	
19.	Drugs Charged to Patients	91,900,365	570,444,427	0.161103	23,524,305		3,789,836	
20.	Renal Dialysis	4,064,650	25,929,157	0.156760	539,111		84,511	
21.	Ambulance	4,523,241	4,375,765	1.033703	5,414		5,596	
22.	Brace and Plaster Rm	339,152	1,051,849	0.322434	2,582		833	
23.	Kidney Acquisition	4,664,913	4,858,359	0.960183	670		643	
24.	Liver Acquisition	2,784,446	2,710,563	1.027257	267,030		274,308	
25.	Heart Acquisition	2,061,265	3,135,323	0.657433	126,230		82,988	
26.	Pancreas Acquisition	1,248,059	1,789,923	0.697270				
27.	Implants Dev. Charged	39,986,072	154,325,995	0.259101	3,484,154		902,748	
28.	Lung Acquisition	1,173,380	658,915	1.780776				
29.	Cardiac Rehab	201,676	543,371	0.371157				
30.	CT Scan	7,642,588	145,263,524	0.052612	1,813,491		95,411	
31.	MRI	6,963,920	79,347,371	0.087765	1,505,746		132,152	
32.	Cardiac Cath	6,053,015	57,989,748	0.104381	389,755		40,683	
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	112,756,436	268,103,954	0.420570	4,314,612		1,814,596	
44.	Emergency	30,828,600	196,859,113	0.156602	198,891		31,147	
45.	Observation	3,386,229	7,946,303	0.426139				
46.	Total				128,534,359		21,988,440	

* 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-Revised

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	18,831,895			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	14,326			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,314.53			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,498			
3.	Program general inpatient routine cost (Line 1c X Line 2)	11,170,876			
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)	11,170,876			

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	8,596,057	4,930	1,743.62	1,008	1,757,569
9.	Coronary Care Unit	2,941,007	1,552	1,894.98	10	18,950
10.	Burn ICU	1,040,330	662	1,571.50	210	330,015
11.	Nursery Special Care	4,122,257	4,470	922.21	2,992	2,759,252
12.	Nursery ICU	26,308,034	13,790	1,907.76	9,652	18,413,700
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	762,804	1,431	533.06	609	324,634
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					21,988,440
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					56,763,436

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

Preliminary-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	
		From:	07/01/2011 To: 06/30/2012

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)	
		(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-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan							
31.	MRI							
32.	Cardiac Cath							
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-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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.	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-Revised

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)		56,763,436	
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)		6,522,776	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		63,286,212	
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)		128,534,359	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		42,254,949	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		4,461,750	
F. Coronary Care Unit			
G. Burn ICU		1,131,270	
H. Nursery Special Care		7,479,968	
I. Nursery ICU		38,594,133	
J. Other			
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		1,548,825	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		224,005,254	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			160,719,042
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-Revised

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	63,286,212	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	63,286,212	
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)	63,286,212	

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-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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)	160,719,042
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-Revised

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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	4,081,352	325,012,766	0.012558	14,133,937		177,494	
2.	Recovery Room							
3.	Delivery and Labor Room	1,543,369	16,413,166	0.094032				
4.	Anesthesiology	1,154,669	104,921,704	0.011005	4,331,254		47,665	
5.	Radiology - Diagnostic	1,474,774	151,946,789	0.009706	5,245,362		50,911	
6.	Radiology - Therapeutic	1,028,912	83,138,188	0.012376	57,544		712	
7.	Nuclear Medicine							
8.	Laboratory	3,578,328	354,649,047	0.010090	12,866,044		129,818	
9.	Blood							
10.	Blood - Administration	320,106	100,820,599	0.003175	7,017,404		22,280	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	188,277	113,335,133	0.001661	2,039,284		3,387	
17.	EEG	1,097,506	14,157,972	0.077519	1,299,543		100,739	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	331,538	25,929,157	0.012786	539,111		6,893	
21.	Ambulance							
22.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan	1,497,639	145,263,524	0.010310	1,813,491		18,697	
31.	MRI	777,401	79,347,371	0.009797	1,505,746		14,752	
32.	Cardiac Cath	97,531	57,989,748	0.001682	389,755		656	
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	16,028,169	268,103,954	0.059783	4,314,612		257,940	
44.	Emergency	5,441,804	196,859,113	0.027643	198,891		5,498	
45.	Observation							
46.	Ancillary Total						837,442	

* 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-Revised

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

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	5,921,641	14,326	413.35	8,498		3,512,648	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	849,407	4,930	172.29	1,008		173,668	
52.	Coronary Care Unit	111,969	1,552	72.14	10		721	
53.	Burn ICU	17,655	662	26.67	210		5,601	
54.	Nursery Special Care	548,754	4,470	122.76	2,992		367,298	
55.	Nursery ICU	2,069,257	13,790	150.05	9,652		1,448,283	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	416,181	1,431	290.83	609		177,115	
67.	Routine Total (lines 47-66)						5,685,334	
68.	Ancillary Total (from line 46)						837,442	
69.	Total (Lines 67-68)						6,522,776	

Preliminary-Revised

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	22,370		22,370
Newborn Days	609		609
Total Inpatient Revenue	224,005,254		224,005,254
Ancillary Revenue	128,534,359		128,534,359
Routine Revenue	95,470,895		95,470,895
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]