

# 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: 07/01/2013	To: 06/30/2014

**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 checked="" type="checkbox"/>	<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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Children's Hospital

**Health Care Program**

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

<input checked="" type="checkbox"/> Medicaid Hospital <input checked="" type="checkbox"/>	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> 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-Comer 3466 for the cost report beginning 07/01/2013 and ending 06/30/2014 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

\_\_\_\_\_  
Name (Typewritten)  
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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2013 To: 06/30/2014

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	58	21,170		13,141	62.07%		4,623	8.23
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		5,468	74.90%			
6.	Coronary Care Unit	10	3,650		1	0.03%			
7.	Burn ICU	2	730		557	76.30%			
8.	Nursery Special Care	22	8,030		5,080	63.26%			
9.	Nursery ICU	47	17,155		13,822	80.57%			
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		953	13.74%			
22.	<b>Total</b>	<b>178</b>	<b>64,970</b>		<b>39,022</b>	<b>60.06%</b>		<b>4,623</b>	<b>8.23</b>
23.	Observation Bed Days				691				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,378			2,797	7.86
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,930				
6.	Coronary Care Unit				1				
7.	Burn ICU				232				
8.	Nursery Special Care				3,508				
9.	Nursery ICU				8,930				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				505				
22.	<b>Total</b>				<b>22,484</b>	<b>57.62%</b>		<b>2,797</b>	<b>7.86</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

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2013</b> To: <b>06/30/2014</b>

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	102,941,028	426,467,258	0.241381	14,247,215		3,439,007	
2.	Recovery Room							
3.	Delivery and Labor Room	10,691,076	19,521,773	0.547649				
4.	Anesthesiology	10,741,459	145,335,618	0.073908	4,207,080		310,937	
5.	Radiology - Diagnostic	46,719,854	188,387,600	0.247999	4,474,055		1,109,561	
6.	Radiology - Therapeutic	14,017,136	108,178,811	0.129574	324,227		42,011	
7.	Nuclear Medicine							
8.	Laboratory	59,636,884	505,988,816	0.117862	15,610,218		1,839,852	
9.	Blood							
10.	Blood - Administration	19,555,158	116,127,982	0.168393	5,274,180		888,135	
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,226,739	118,828,209	0.170218	24,609,108		4,188,913	
13.	Physical Therapy	10,992,576	39,343,103	0.279403	1,310,937		366,280	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	15,061,174	119,804,958	0.125714	542,903		68,251	
17.	EEG	5,571,532	24,622,493	0.226278	2,027,171		458,704	
18.	Med. / Surg. Supplies	29,423,770	91,316,952	0.322216	1,163,072		374,760	
19.	Drugs Charged to Patients	104,451,550	691,191,732	0.151118	23,255,430		3,514,314	
20.	Renal Dialysis	4,913,616	23,194,303	0.211846	339,790		71,983	
21.	Ambulance	1,405,803	11,148	126.103606	6,936		874,655	
22.	Brace and Plaster Rm	234,686	1,044,096	0.224774	3,200		719	
23.	Kidney Acquisition	5,657,277	4,976,725	1.136747				
24.	Liver Acquisition	2,231,911	2,748,682	0.811993	285,722		232,004	
25.	Heart Acquisition	2,136,672	3,210,227	0.665583				
26.	Pancreas Acquisition	277,723	690,394	0.402267				
27.	Implants Dev. Charged	45,024,469	166,775,047	0.269971	4,770,019		1,287,767	
28.	Lung Acquisition	1,672,472	2,430,005	0.688259				
29.	Cardiac Rehab	213,324	624,883	0.341382				
30.	CT Scan	9,016,953	210,125,864	0.042912	1,815,623		77,912	
31.	MRI	7,445,064	108,788,677	0.068436	2,134,443		146,073	
32.	Cardiac Cath	1,288,403	61,221,323	0.021045	2,461,383		51,800	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	123,245,635	314,038,076	0.392454	2,700,373		1,059,772	
44.	Emergency	33,288,480	196,625,549	0.169299				
45.	Observation							
46.	<b>Total</b>				<b>111,563,085</b>		<b>20,403,410</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: 07/01/2013 To: 06/30/2014

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	18,691,062			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	13,832			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,351.29			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,378			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,618,528			
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)	8,618,528			

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	13,084,718	5,468	2,392.96	2,930	7,011,373
9.	Coronary Care Unit	2,781	1	2,781.00	1	2,781
10.	Burn ICU	841,283	557	1,510.38	232	350,408
11.	Nursery Special Care	4,758,374	5,080	936.69	3,508	3,285,909
12.	Nursery ICU	29,170,464	13,822	2,110.44	8,930	18,846,229
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	638,662	953	670.16	505	338,431
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					20,403,410
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>58,857,069</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: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2013</b> To: <b>06/30/2014</b>

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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	<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>07/01/2013</b> To: <b>06/30/2014</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.	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							
	<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>07/01/2013</b> To: <b>06/30/2014</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: 07/01/2013 To: 06/30/2014	
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)	58,857,069	
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)	5,359,312	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>64,216,381</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)	111,563,085	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	20,270,571	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	22,950,796	
	F. Coronary Care Unit		
	G. Burn ICU	1,844,759	
	H. Nursery Special Care	8,684,528	
	I. Nursery ICU	50,836,357	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,059,171	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>218,209,267</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		153,992,886
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: 07/01/2013 To: 06/30/2014

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)	64,216,381	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	64,216,381	
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>64,216,381</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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2013 To: 06/30/2014

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	153,992,886
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.	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	Period Covered by Statement: From: 07/01/2013 To: 06/30/2014

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

**Part A. Cost of Physicians Direct Medical and Surgical Services**

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

**Part B. Program Data**

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

**Part C. Program Cost**

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

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2013</b> To: <b>06/30/2014</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)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	10,512,142	426,467,258	0.024649	14,247,215		351,180	
2.	Recovery Room							
3.	Delivery and Labor Room	3,319,296	19,521,773	0.170030				
4.	Anesthesiology	7,024,702	145,335,618	0.048334	4,207,080		203,345	
5.	Radiology - Diagnostic	4,396,666	188,387,600	0.023338	4,474,055		104,415	
6.	Radiology - Therapeutic	1,040,004	108,178,811	0.009614	324,227		3,117	
7.	Nuclear Medicine							
8.	Laboratory	5,760,504	505,988,816	0.011385	15,610,218		177,722	
9.	Blood							
10.	Blood - Administration	37,366	116,127,982	0.000322	5,274,180		1,698	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	541,799	119,804,958	0.004522	542,903		2,455	
17.	EEG	772,219	24,622,493	0.031362	2,027,171		63,576	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	124,552	23,194,303	0.005370	339,790		1,825	
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	622,757	210,125,864	0.002964	1,815,623		5,382	
31.	MRI	130,779	108,788,677	0.001202	2,134,443		2,566	
32.	Cardiac Cath	660,123	61,221,323	0.010783	2,461,383		26,541	
33.	Other							
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	10,094,894	314,038,076	0.032145	2,700,373		86,803	
44.	Emergency	3,051,510	196,625,549	0.015519				
45.	Observation							
46.	<b>Ancillary Total</b>						<b>1,030,625</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>07/01/2013</b> To: <b>06/30/2014</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	3,431,638	13,832	248.09	6,378		1,582,318	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,381,497	5,468	252.65	2,930		740,265	
52.	Coronary Care Unit	559	1	559.00	1		559	
53.	Burn ICU	106,640	557	191.45	232		44,416	
54.	Nursery Special Care	37,366	5,080	7.36	3,508		25,819	
55.	Nursery ICU	2,995,463	13,822	216.72	8,930		1,935,310	
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>4,328,687</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>1,030,625</b>	
69.	<b>Total (Lines 67-68)</b>						<b>5,359,312</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: 07/01/2013 To: 06/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	21,979		21,979
Newborn Days	505		505
Total Inpatient Revenue	218,209,267		218,209,267
Ancillary Revenue	111,563,085		111,563,085
Routine Revenue	106,646,182		106,646,182
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

- Room & Board costs split between Acute and Children's Hospital.
- Observation Bed Days were taken from the as filed W/S S-3 and split between Acute and Children's Hospital
- BHF Page 3 - total costs agree with W/S C Part 1, column 1
- BHF Page 3 - Total Nursery Special Care days and Nursery ICU days adjusted to agree with W/S S-3, Col. 8.
- GME costs were adjusted to as filed W/S B Part 1, column 25 and split between Acute and Children's Hospital.