

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: St. Louis Children's Hospital		Medicare Provider Number: 26-3301
Street: One Children's Place		Medicaid Provider Number: 19018
City: St. Louis	State: Missouri	Zip: 63110
Period Covered by Statement:	From: 01/01/2012	To: 12/31/2012

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ XXXX XXXX Other (Specify)	☐ Corporation	☐ County
		☐ Township
		☐ Hospital District
		☐ Other (Specify)

Type of Hospital

☐ XXXX XXXX General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify)

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)) St. Louis Children's Hospital 19018 for the cost report beginning 01/01/2012 and ending 12/31/2012 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	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

BHF Page 2

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	194	71,004		38,433	54.13%	11,255	11,251	6.41
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	28	10,248		7,330	71.53%			
6.	Coronary Care Unit	12	4,392		4,317	98.29%			
7.	NICU	78	28,548		22,046	77.22%			
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	312	114,192		72,126	63.16%	11,255	11,251	6.41
23.	Observation Bed Days				2,544				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,951		1,381	1,381	6.86
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				898				
6.	Coronary Care Unit				558				
7.	NICU				3,063				
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				9,470	13.13%	1,381	1,381	6.86

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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	21,187,657	47,437,012	0.446648	6,080,416		2,715,806	
2.	Recovery Room	5,488,858	8,601,902	0.638098	272,149		173,658	
3.	Delivery and Labor Room							
4.	Anesthesiology	771,497	10,809,548	0.071372	860,104		61,387	
5.	Radiology - Diagnostic	7,066,305	33,042,033	0.213858	1,695,710		362,641	
6.	Radiology - Therapeutic	1,309,071	3,983,517	0.328622	268,089		88,100	
7.	Nuclear Medicine							
8.	Laboratory	20,780,343	99,681,233	0.208468	8,593,047		1,791,375	
9.	Blood							
10.	Blood - Administration	5,926,821	16,827,371	0.352213	1,896,235		667,879	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,449,704	26,990,872	0.313058	4,169,742		1,305,371	
13.	Physical Therapy	6,977,172	8,130,640	0.858133	379,221		325,422	
14.	Occupational Therapy	1,693,524	4,732,842	0.357824	312,949		111,981	
15.	Speech Pathology	2,798,407	5,390,477	0.519139	159,256		82,676	
16.	EKG	2,364,564	4,720,102	0.500956	566,830		283,957	
17.	EEG	1,140,112	4,396,273	0.259336	299,989		77,798	
18.	Med. / Surg. Supplies	24,149,594	73,631,935	0.327977	3,194,097		1,047,590	
19.	Drugs Charged to Patients	33,427,870	95,011,199	0.351831	9,114,735		3,206,846	
20.	Renal Dialysis	631,088	1,182,932	0.533495	186,551		99,524	
21.	Ambulance	4,555,947	5,819,175	0.782920	685,203		536,459	
22.	CT Scan	226,328	11,273,451	0.020076	755,662		15,171	
23.	MRI	1,330,185	30,688,167	0.043345	1,268,104		54,966	
24.	Cardiac Cath	2,798,343	8,106,954	0.345178	1,073,332		370,491	
25.	Implantable Devices	15,470,024	36,177,578	0.427614	558		239	
26.	Ambulatory Surgery	6,108,287	5,425,815	1.125782	9,234		10,395	
27.	Home Program Dialy.	196	724,824	0.000270	58,891		16	
28.	Organ Acq. - Heart	1,594,495	2,466,901	0.646355	247,097		159,712	
29.	Organ Acq. - Liver	691,716	1,045,141	0.661840	119,235		78,914	
30.	Organ Acq. - Other	781,845	1,258,008	0.621494	259,653		161,373	
31.	Organ Acq. - Kidney	195,171	356,479	0.547496				
32.	Organ Acq. - Lung	812,240	1,044,833	0.777387				
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	18,859,271	12,954,358	1.455824	219,983		320,257	
44.	Emergency	16,807,767	38,704,361	0.434260	1,021,965		443,799	
45.	Observation	3,305,826	2,499,248	1.322728	1,148		1,518	
46.	Total				43,769,185		14,555,321	

* 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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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)	53,248,010			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	40,977			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,299.46			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,951			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,433,626			
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)	6,433,626			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (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	17,749,535	7,330	2,421.49	898	2,174,498
9.	Coronary Care Unit	11,844,087	4,317	2,743.59	558	1,530,923
10.	NICU	38,286,549	22,046	1,736.67	3,063	5,319,420
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)					14,555,321
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					30,013,788

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

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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.	NICU						
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 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45) (5A) (5B)		Program Expenses (Col. 4 X Cols. 5A-B) (6A) (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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	222,597	47,437,012	0.004692	6,080,416		28,529	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,840,183	10,809,548	0.355258	860,104		305,559	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,223,000	99,681,233	0.012269	8,593,047		105,428	
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	161,544	1,182,932	0.136562	186,551		25,476	
21.	Ambulance	329,244	5,819,175	0.056579	685,203		38,768	
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	Ambulatory Surgery							
27.	Home Program Dialy.							
28.	Organ Acq. - Heart							
29.	Organ Acq. - Liver							
30.	Organ Acq. - Other							
31.	Organ Acq. - Kidney							
32.	Organ Acq. - Lung							
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	508,730	12,954,358	0.039271	219,983		8,639	
44.	Emergency	1,858,927	38,704,361	0.048029	1,021,965		49,084	
45.	Observation							
46.	Ancillary Total						561,483	

* 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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	436,463	40,977	10.65	4,951		52,728	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU							
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)						52,728	
68.	Ancillary Total (from line 46)						561,483	
69.	Total (Lines 67-68)						614,211	

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

BHF Page 7

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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)		30,013,788	
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)		614,211	
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)		4,464,116	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		35,092,115	
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)		43,769,185	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		5,829,980	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		2,507,969	
F. Coronary Care Unit		1,554,122	
G. NICU		8,311,263	
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)		61,972,519	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			26,880,404
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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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)	35,092,115	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	35,092,115	
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)	35,092,115	

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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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)	26,880,404
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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	4,388,675	47,437,012	0.092516	6,080,416		562,536	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,692,395	33,042,033	0.051219	1,695,710		86,853	
6.	Radiology - Therapeutic	750,427	3,983,517	0.188383	268,089		50,503	
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	367,492	4,396,273	0.083592	299,989		25,077	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	176,045	1,182,932	0.148821	186,551		27,763	
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath	1,284,813	8,106,954	0.158483	1,073,332		170,105	
25.	Implantable Devices							
26.	Ambulatory Surgery	1,204,484	5,425,815	0.221991	9,234		2,050	
27.	Home Program Dialy.							
28.	Organ Acq. - Heart							
29.	Organ Acq. - Liver							
30.	Organ Acq. - Other							
31.	Organ Acq. - Kidney							
32.	Organ Acq. - Lung							
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	10,522,307	12,954,358	0.812260	219,983		178,683	
44.	Emergency	3,335,494	38,704,361	0.086179	1,021,965		88,072	
45.	Observation							
46.	Ancillary Total						1,191,642	

* 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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	15,973,368	40,977	389.81	4,951		1,929,949	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,530,005	7,330	481.58	898		432,459	
52.	Coronary Care Unit	1,954,911	4,317	452.84	558		252,685	
53.	NICU	4,731,519	22,046	214.62	3,063		657,381	
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)						3,272,474	
68.	Ancillary Total (from line 46)						1,191,642	
69.	Total (Lines 67-68)						4,464,116	

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,470		9,470
Newborn Days			
Total Inpatient Revenue	61,972,519		61,972,519
Ancillary Revenue	43,769,185		43,769,185
Routine Revenue	18,203,334		18,203,334
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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