

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: Saint Louis University Hospital		Medicare Provider Number: 26-0105	
Street: 3635 Vista at Grand Blvd.		Medicaid Provider Number: 19025	
City: St. Louis	State: Missouri	Zip: 63110	
Period Covered by Statement:	From: 06/01/2015	To: 08/31/2015	

Type of Control

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

Type of Hospital

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

Health Care Program

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

☐ XXXX Medicaid Hospital XXXX	☐ 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)) Saint Louis University Hospit: 19025 for the cost report beginning 06/01/2015 and ending 08/31/2015 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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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	222	20,424	2,225	16,307	79.84%		3,880	5.49
2.	Psych	40	3,680	207	2,909	79.05%		403	7.22
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	14	1,288		1,007	78.18%			
6.	Coronary Care Unit								
7.	6th ICU	11	1,012		907	89.62%			
8.	7th ICU	15	1,380		890	64.49%			
9.	8th ICU	11	1,012		927	91.60%			
10.	5th ICU	14	1,288		1,244	96.58%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	327	30,084	2,432	24,191	80.41%		4,283	5.65
23.	Observation Bed Days				1,121				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics			257	559			138	5.36
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				21				
6.	Coronary Care Unit								
7.	6th ICU				36				
8.	7th ICU				19				
9.	8th ICU				71				
10.	5th ICU				33				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total			257	739	3.05%		138	5.36

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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	5,862,375	31,563,517	0.185733	869,306		161,459	
2.	Recovery Room	1,316,797	4,251,236	0.309745	70,066		21,703	
3.	Delivery and Labor Room							
4.	Anesthesiology	325,088	5,985,768	0.054310	173,896		9,444	
5.	Radiology - Diagnostic	4,446,016	60,301,159	0.073730	1,772,789		130,708	
6.	Radiology - Therapeutic	662,076	4,402,191	0.150397	7,664		1,153	
7.	Nuclear Medicine	922,076	444,816	2.072938	6,814		14,125	
8.	Laboratory	6,541,232	59,424,980	0.110075	1,607,146		176,907	
9.	Blood							
10.	Blood - Administration	1,340,031	5,273,805	0.254092	205,956		52,332	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,134,033	7,570,944	0.149788	369,516		55,349	
13.	Physical Therapy	1,424,052	5,454,730	0.261067	155,701		40,648	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,989,011	15,778,053	0.126062	256,280		32,307	
17.	EEG	322,452	612,571	0.526391	10,368		5,458	
18.	Med. / Surg. Supplies	6,356,136	31,431,381	0.202223	1,273,048		257,440	
19.	Drugs Charged to Patients	10,756,269	90,091,669	0.119392	3,039,885		362,938	
20.	Renal Dialysis	545,294	1,346,990	0.404824	10,888		4,408	
21.	Ambulance							
22.	Endoscopy	878,127	4,403,886	0.199398	66,478		13,256	
23.	PET Imaging	259,855	6,539,513	0.039736	42,723		1,698	
24.	Implantable Devices	7,387,599	22,209,176	0.332637	2,012,974		669,590	
25.	Bone Marrow	521,800	520,332	1.002821				
26.	Transplant Clinic							
27.	Kidney Acquisition	1,361,672	2,872,032	0.474114				
28.	Liver Acquisition	994,753	986,877	1.007981				
29.	Pancreas Acquisition	9,577	9,233	1.037258				
30.	Corneal Transplant	76,912	260,242	0.295540				
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	2,751,435	12,274,112	0.224166				
44.	Emergency	3,450,832	28,553,609	0.120854	357,179		43,167	
45.	Observation	837,353	1,592,168	0.525920	20,661		10,866	
46.	Total				12,329,338		2,064,956	

* 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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2015 To: 08/31/2015

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)	13,017,707	2,622,934		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	17,428	2,909		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	746.94	901.66		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	559			
3.	Program general inpatient routine cost (Line 1c X Line 2)	417,539			
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)	257			
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)	417,539			

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	1,601,929	1,007	1,590.79	21	33,407
9.	Coronary Care Unit					
10.	6th ICU	1,349,657	907	1,488.05	36	53,570
11.	7th ICU	1,444,863	890	1,623.44	19	30,845
12.	8th ICU	1,409,868	927	1,520.89	71	107,983
13.	5th ICU	1,749,633	1,244	1,406.46	33	46,413
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)					2,064,956
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,754,713

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

Preliminary

Medicare Provider Number:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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.	6th ICU						
9.	7th ICU						
10.	8th ICU						
11.	5th ICU						
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)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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.	Endoscopy							
23.	PET Imaging							
24.	Implantable Devices							
25.	Bone Marrow							
26.	Transplant Clinic							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Pancreas Acquisition							
30.	Corneal Transplant							
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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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.	6th ICU							
54.	7th ICU							
55.	8th ICU							
56.	5th ICU							
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: 26-0105		Medicaid Provider Number: 19025	
Program: Medicaid Hospital		Period Covered by Statement: From: 06/01/2015 To: 08/31/2015	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	2,754,713	
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)	376,470	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,131,183	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	12,329,338	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	985,192	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	90,353	
	F. Coronary Care Unit		
	G. 6th ICU	262,134	
	H. 7th ICU	76,082	
	I. 8th ICU	247,064	
	J. 5th ICU	187,240	
	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)	14,177,403	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		11,046,220
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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2015 To: 08/31/2015

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)	3,131,183	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,131,183	
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)	3,131,183	

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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2015 To: 08/31/2015

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)	11,046,220
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2015 To: 08/31/2015

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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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	1,442,805	31,563,517	0.045711	869,306		39,737	
2.	Recovery Room	106,885	4,251,236	0.025142	70,066		1,762	
3.	Delivery and Labor Room							
4.	Anesthesiology	897,739	5,985,768	0.149979	173,896		26,081	
5.	Radiology - Diagnostic	828,276	60,301,159	0.013736	1,772,789		24,351	
6.	Radiology - Therapeutic	160,304	4,402,191	0.036415	7,664		279	
7.	Nuclear Medicine							
8.	Laboratory	587,797	59,424,980	0.009891	1,607,146		15,896	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	267,188	612,571	0.436175	10,368		4,522	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy							
23.	PET Imaging							
24.	Implantable Devices							
25.	Bone Marrow	80,152	520,332	0.154040				
26.	Transplant Clinic							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Pancreas Acquisition							
30.	Corneal Transplant							
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	80,152	12,274,112	0.006530				
44.	Emergency	400,783	28,553,609	0.014036	357,179		5,013	
45.	Observation							
46.	Ancillary Total						117,641	

* 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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2015 To: 08/31/2015

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	5,557,427	17,428	318.88	559		178,254	
48.	Psych	320,631	2,909	110.22				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	435,515	1,007	432.49	21		9,082	
52.	Coronary Care Unit							
53.	6th ICU	435,515	907	480.17	36		17,286	
54.	7th ICU	435,515	890	489.34	19		9,297	
55.	8th ICU	435,515	927	469.81	71		33,357	
56.	5th ICU	435,515	1,244	350.09	33		11,553	
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)						258,829	
68.	Ancillary Total (from line 46)						117,641	
69.	Total (Lines 67-68)						376,470	

Preliminary

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2015 To: 08/31/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	739		739
Newborn Days			
Total Inpatient Revenue	14,177,403		14,177,403
Ancillary Revenue	12,329,338		12,329,338
Routine Revenue	1,848,065		1,848,065
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]