

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: 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: 01/01/2015	To: 12/31/2015	

Type of Contrc

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> XXXX XXXX Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospita

<input type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

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

<input type="checkbox"/> XXXX XXXX Medicaid Hospital	<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)) St. Louis Children's Hospital 19018 for the cost report beginning 01/01/2015 and ending 12/31/2015 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

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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	157	57,305		39,684	69.25%		10,437	7.22
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	45	16,425		7,318	44.55%			
6.	Coronary Care Unit								
7.	NICU	92	33,580		28,313	84.32%			
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	294	107,310		75,315	70.18%		10,437	7.22
23.	Observation Bed Days				3,812				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,461			931	9.54
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,347				
6.	Coronary Care Unit								
7.	NICU				4,074				
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				8,882	11.79%		931	9.54

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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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 (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)	(2)	(3)	(4)	(5)	(6)	(7)
		1.	Operating Room	31,419,706	79,220,593	0.396610	3,547,850	
2.	Recovery Room	13,921,062	20,434,323	0.681259	249,454		169,943	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,347,089	22,976,622	0.102151	789,777		80,677	
5.	Radiology - Diagnostic	8,252,898	37,163,189	0.222072	1,591,559		353,441	
6.	Radiology - Therapeutic	2,217,799	7,548,476	0.293808	40,116		11,786	
7.	Nuclear Medicine							
8.	Laboratory	24,422,816	111,947,953	0.218162	7,617,712		1,661,895	
9.	Blood							
10.	Blood - Administration	5,825,924	19,673,585	0.296129	1,021,750		302,570	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,624,629	33,699,310	0.315277	5,394,970		1,700,910	
13.	Physical Therapy	9,012,495	9,378,092	0.961016	356,705		342,799	
14.	Occupational Therapy	1,843,834	4,829,653	0.381774	324,453		123,868	
15.	Speech Pathology	1,145,544	6,055,493	0.189174	159,891		30,247	
16.	EKG	2,759,319	5,461,732	0.505210	625,000		315,756	
17.	EEG	1,488,118	6,003,368	0.247881	349,398		86,609	
18.	Med. / Surg. Supplies	17,650,631	53,349,767	0.330847	5,620,524		1,859,534	
19.	Drugs Charged to Patients	37,359,226	111,365,616	0.335465	8,760,577		2,938,867	
20.	Renal Dialysis	1,653,905	2,257,910	0.732494	61,370		44,953	
21.	Ambulance	6,038,865	8,800,792	0.686173	908,689		623,518	
22.	CT Scan	286,292	13,161,934	0.021752	461,647		10,042	
23.	MRI	1,660,917	39,724,440	0.041811	828,461		34,639	
24.	Cardiac Cath	1,843,978	13,211,725	0.139571	158,595		22,135	
25.	Implantable Devices	15,643,175	28,014,789	0.558390	1,014,168		566,301	
26.	Home Dialysis	2,231	770,559	0.002895				
27.	Kidney Acquisition	139,328	407,491	0.341917	64,527		22,063	
28.	Liver Acquisition	896,735	1,290,419	0.694918	285,480		198,385	
29.	Heart Acquisition	1,358,834	1,967,456	0.690655				
30.	Lung Acquisition	496,342	709,847	0.699224				
31.	Other Organ Acquisit	1,346,744	2,075,201	0.648970	190,400		123,564	
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	14,266,794	10,736,992	1.328751	121,947		162,037	
44.	Emergency	18,425,650	49,725,901	0.370544	832,525		308,487	
45.	Observation	6,130,611	6,404,114	0.957293	68,804		65,866	
46.	Total				41,446,349		13,568,005	

* 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 Cc

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)	69,952,124			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	43,496			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,608.24			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,461			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,566,119			
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)	5,566,119			

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	23,181,365	7,318	3,167.72	1,347	4,266,919
9.	Coronary Care Unit					
10.	NICU	54,506,953	28,313	1,925.16	4,074	7,843,102
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)					13,568,005
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					31,244,145

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

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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.	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)	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 (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

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	227,538	79,220,593	0.002872	3,547,850		10,189	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	5,097,870	22,976,622	0.221872	789,777		175,229	
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	85,155	8,800,792	0.009676	908,689		8,792	
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Heart Acquisition							
30.	Lung Acquisition							
31.	Other Organ Acquisit							
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	813,957	10,736,992	0.075809	121,947		9,245	
44.	Emergency	1,402,156	49,725,901	0.028198	832,525		23,476	
45.	Observation							
46.	Ancillary Total						226,931	

* 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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

Line No.	Cost Centers	Professional Component	Total Days Including Private	Professional Component Cost Per Diem	Program Days Including Private	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	(Col. 1 / Col. 2)	(BHF Pg. 2 Pt. II, Col. 4)	(BHF Page 3, Col. 5)	(Col. 3 X Col. 4)	(Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	30,702	43,496	0.71	3,461		2,457	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	18,358	28,313	0.65	4,074		2,648	
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)						5,105	
68.	Ancillary Total (from line 46)						226,931	
69.	Total (Lines 67-68)						232,036	

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)	31,244,145	
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)	232,036	
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)	4,965,050	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	36,441,231	
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)	41,446,349	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,907,195	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	6,989,283	
	F. Coronary Care Unit		
	G. NICU	13,159,005	
	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)	66,501,832	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		30,060,601
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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)	36,441,231	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	36,441,231	
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)	36,441,231	

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

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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

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)		30,060,601
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 Charge

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)	(2A)	(2B)	(3A)
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: 01/01/2015 To: 12/31/2015

Part I - Apportionment of Cost for the Services of Teaching Physician

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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Pediatrics	Psych	Rehab	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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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	12,578,521	79,220,593	0.158778	3,547,850		563,321	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,194,567	37,163,189	0.032144	1,591,559		51,159	
6.	Radiology - Therapeutic	1,446,569	7,548,476	0.191637	40,116		7,688	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	389,586	33,699,310	0.011561	5,394,970		62,371	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology	928,340	6,055,493	0.153305	159,891		24,512	
16.	EKG							
17.	EEG	824,288	6,003,368	0.137304	349,398		47,974	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	865,543	13,161,934	0.065761	461,647		30,358	
23.	MRI	865,543	39,724,440	0.021789	828,461		18,051	
24.	Cardiac Cath	796,649	13,211,725	0.060299	158,595		9,563	
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Heart Acquisition							
30.	Lung Acquisition							
31.	Other Organ Acquisit							
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	11,964,573	10,736,992	1.114332	121,947		135,889	
44.	Emergency	8,232,109	49,725,901	0.165550	832,525		137,825	
45.	Observation							
46.	Ancillary Total						1,088,711	

* 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: 01/01/2015 To: 12/31/2015

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	19,479,495	43,496	447.85	3,461		1,550,009	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	6,047,218	7,318	826.35	1,347		1,113,093	
52.	Coronary Care Unit							
53.	NICU	8,431,678	28,313	297.80	4,074		1,213,237	
54.	Other							
55.	Other			#VALUE!				
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)						3,876,339	
68.	Ancillary Total (from line 46)						1,088,711	
69.	Total (Lines 67-68)						4,965,050	

