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:** 01/01/2011 / **To:** 12/31/2011

Type of Control

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

Type of Hospital

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	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 01/01/2011 and ending 12/31/2011 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

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:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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	70,810		38,062	53.75%	11,587	11,581	6.18
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	40	14,600		11,550	79.11%			
6.	Coronary Care Unit								
7.	NICU	78	28,470		21,912	76.97%			
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**	**113,880**		**71,524**	**62.81%**	**11,587**	**11,581**	**6.18**
23.	Observation Bed Days				2,356				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,758		1,373	1,373	6.45
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,397				
6.	Coronary Care Unit								
7.	NICU				2,698				
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**				**8,853**	**12.38%**	**1,373**	**1,373**	**6.45**

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:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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	24,256,980	44,590,693	0.543992	3,509,897		1,909,356	
2.	Recovery Room	4,884,075	7,685,440	0.635497	241,091		153,213	
3.	Delivery and Labor Room							
4.	Anesthesiology	158,061	10,264,696	0.015399	585,056		9,009	
5.	Radiology - Diagnostic	6,123,423	30,472,946	0.200946	1,488,630		299,134	
6.	Radiology - Therapeutic	1,572,135	4,229,952	0.371667	310,488		115,398	
7.	Nuclear Medicine							
8.	Laboratory	19,564,716	95,928,036	0.203952	7,516,114		1,532,926	
9.	Blood							
10.	Blood - Administration	5,521,612	15,957,292	0.346024	2,294,597		793,986	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,584,268	26,235,998	0.327194	3,015,654		986,704	
13.	Physical Therapy	6,295,866	6,960,126	0.904562	340,589		308,084	
14.	Occupational Therapy	1,629,945	4,291,156	0.379838	317,317		120,529	
15.	Speech Pathology	2,903,515	5,847,839	0.496511	151,287		75,116	
16.	EKG	2,373,160	4,686,941	0.506335	520,997		263,799	
17.	EEG	1,066,213	3,946,081	0.270195	374,934		101,305	
18.	Med. / Surg. Supplies	22,812,530	74,068,878	0.307991	7,310,853		2,251,677	
19.	Drugs Charged to Patients	37,559,499	93,374,496	0.402246	9,843,814		3,959,635	
20.	Renal Dialysis	569,150	830,863	0.685011	73,393		50,275	
21.	Ambulance	4,843,942	4,643,158	1.043243	635,387		662,863	
22.	CT Scan	546,777	10,774,464	0.050747	598,707		30,383	
23.	MRI	1,533,551	28,325,051	0.054141	1,012,288		54,806	
24.	Cardiac Cath	3,061,709	6,464,009	0.473655	203,508		96,393	
25.	Med. Devices/Implants	11,742,316	33,193,644	0.353752	1,146,066		405,423	
26.	Same Day Surgery	6,636,930	4,939,877	1.343542	343		461	
27.	Home Program Dialysis	161,103	797,706	0.201958	15,590		3,149	
28.	Kidney Acquisition	208,321	411,010	0.506851				
29.	Heart Acquisition	1,541,743	1,380,211	1.117034	276,431		308,783	
30.	Liver Acquisition	551,564	855,514	0.644717	173,947		112,147	
31.	Lung Acquisition	1,227,593	2,624,065	0.467821	81,065		37,924	
32.	Other Organ Acq-BMT	518,135	938,171	0.552282	233,041		128,704	
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	16,449,531	12,027,643	1.367644	132,258		180,882	
44.	Emergency	15,920,589	30,919,507	0.514904	795,771		409,746	
45.	Observation	2,970,657	2,205,833	1.346728	28,735		38,698	
46.	**Total**				**43,227,848**		**15,400,508**	

* 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:	Medicaid Provider Number:			
26-3301	19018			
Program:	**Period Covered by Statement:**			
Medicaid Hospital	From:	01/01/2011	To:	12/31/2011

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)	50,962,687			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	40,418			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,260.89			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,758			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,999,315			
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)	5,999,315			

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	28,693,607	11,550	2,484.29	1,397	3,470,553
9.	Coronary Care Unit					
10.	NICU	35,009,628	21,912	1,597.74	2,698	4,310,703
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)					15,400,508
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**29,181,079**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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	228,814	44,590,693	0.005131	3,509,897		18,009	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	4,188,608	10,264,696	0.408060	585,056		238,738	
5.	Radiology - Diagnostic	5,718	30,472,946	0.000188	1,488,630		280	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	690,772	95,928,036	0.007201	7,516,114		54,124	
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	131,821	830,863	0.158656	73,393		11,644	
21.	Ambulance	278,035	4,643,158	0.059881	635,387		38,048	
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Med. Devices/Implants							
26.	Same Day Surgery							
27.	Home Program Dialysis							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Other Organ Acq-BMT							
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	616,761	12,027,643	0.051279	132,258		6,782	
44.	Emergency	1,482,395	30,919,507	0.047944	795,771		38,152	
45.	Observation							
46.	**Ancillary Total**						**405,777**	

* 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:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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	739,984	40,418	18.31	4,758		87,119	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	19,210	21,912	0.88	2,698		2,374	
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)**						**89,493**	
68.	**Ancillary Total (from line 46)**						**405,777**	
69.	**Total (Lines 67-68)**						**495,270**	

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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)	29,181,079	
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)	495,270	
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)	4,265,415	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**33,941,764**	
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)	43,227,848	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	5,182,604	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,769,882	
	F. Coronary Care Unit		
	G. NICU	7,028,980	
	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)**	59,209,314	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		25,267,550
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:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	33,941,764	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	33,941,764	
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)**	**33,941,764**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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)	25,267,550
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
26-3301	**19018**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2011 To: 12/31/2011**

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:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

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	2,831,185	44,590,693	0.063493	3,509,897		222,854	
2.	Recovery Room	500,101	7,685,440	0.065071	241,091		15,688	
3.	Delivery and Labor Room							
4.	Anesthesiology	242,961	10,264,696	0.023670	585,056		13,848	
5.	Radiology - Diagnostic	1,524,840	30,472,946	0.050039	1,488,630		74,490	
6.	Radiology - Therapeutic	176,412	4,229,952	0.041705	310,488		12,949	
7.	Nuclear Medicine							
8.	Laboratory	2,370,521	95,928,036	0.024711	7,516,114		185,731	
9.	Blood							
10.	Blood - Administration	210,925	15,957,292	0.013218	2,294,597		30,330	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,821,545	26,235,998	0.069429	3,015,654		209,374	
13.	Physical Therapy	1,279,827	6,960,126	0.183880	340,589		62,628	
14.	Occupational Therapy	401,940	4,291,156	0.093667	317,317		29,722	
15.	Speech Pathology	632,520	5,847,839	0.108163	151,287		16,364	
16.	EKG							
17.	EEG	231,047	3,946,081	0.058551	374,934		21,953	
18.	Med. / Surg. Supplies	643,034	74,068,878	0.008682	7,310,853		63,473	
19.	Drugs Charged to Patients	2,292,949	93,374,496	0.024556	9,843,814		241,725	
20.	Renal Dialysis	274,479	830,863	0.330354	73,393		24,246	
21.	Ambulance	1,058,558	4,643,158	0.227982	635,387		144,857	
22.	CT Scan	27,763	10,774,464	0.002577	598,707		1,543	
23.	MRI	245,112	28,325,051	0.008654	1,012,288		8,760	
24.	Cardiac Cath	325,882	6,464,009	0.050415	203,508		10,260	
25.	Med. Devices/Implants							
26.	Same Day Surgery	863,510	4,939,877	0.174804	343		60	
27.	Home Program Dialysis							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Other Organ Acq-BMT							
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	2,205,698	12,027,643	0.183386	132,258		24,254	
44.	Emergency	2,705,092	30,919,507	0.087488	795,771		69,620	
45.	Observation							
46.	**Ancillary Total**						**1,484,729**	

* 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:	**Medicaid Provider Number:**
26-3301	**19018**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2011 To: 12/31/2011**

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	11,061,122	40,418	273.67	4,758		1,302,122	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,432,032	11,550	470.31	1,397		657,023	
52.	Coronary Care Unit							
53.	NICU	6,672,110	21,912	304.50	2,698		821,541	
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)**						**2,780,686**	
68.	**Ancillary Total (from line 46)**						**1,484,729**	
69.	**Total (Lines 67-68)**						**4,265,415**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2011 To: 12/31/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,853		8,853
Newborn Days			
Total Inpatient Revenue	59,209,314		59,209,314
Ancillary Revenue	43,227,848		43,227,848
Routine Revenue	15,981,466		15,981,466
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs/total charges agree with as filed W/S C, with the exception of Speech Pathology charges
BHF Page 3 - Reclassified Blood to Blood Administration
BHF Page 2 - Provider has combined ICU and CCU from the Medicare cost report into one unit on the Medicaid report.
BHF Page 3 - Total Speech Pathology charges were adjusted to agree with as filed W/S C
Adjusted GME costs to agree with as filed W/S B Part 1, column 25