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. Marys Medical Center		**Medicare Provider Number:** 15-0100	
Street: 3700 Washington Ave.		**Medicaid Provider Number:** 5038	
City: Evansville	**State:** Indiana	**Zip:** 47714-0541	
Period Covered by Statement:	**From:** 07/01/2012	**To:** 06/30/2013	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX XXXX	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		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. Marys Medical Center 5038 for the cost report beginning 07/01/2012 and ending 06/30/2013 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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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	294	105,020		50,525	48.11%	17,674	16,257	4.46
2.	Psych	14	5,110		2,948	57.69%	507	576	5.12
3.	Rehab	24	8,760		5,246	59.89%	403	385	13.63
4.	Other (Sub)								
5.	Intensive Care Unit	62	22,630		14,224	62.85%			
6.	Coronary Care Unit	9	3,285		1,449	44.11%			
7.	NICU	40	14,600		6,347	43.47%			
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				3,166				
22.	**Total**	**443**	**159,405**		**83,905**	**52.64%**	**18,584**	**17,218**	**4.69**
23.	Observation Bed Days				12,531				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				741				
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				79				
6.	Coronary Care Unit				4				
7.	NICU				651				
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				187				
22.	**Total**				**1,662**	**1.98%**			

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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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	55,369,827	194,001,176	0.285410	474,871		135,533	
2.	Recovery Room	3,406,209	19,348,302	0.176047	51,170		9,008	
3.	Delivery and Labor Room	5,449,808	13,211,003	0.412520	871,265		359,414	
4.	Anesthesiology	470,962	15,389,761	0.030602	53,068		1,624	
5.	Radiology - Diagnostic	8,505,269	60,793,320	0.139905	136,130		19,045	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	2,699,411	29,484,318	0.091554	21,019		1,924	
8.	Laboratory	16,179,400	85,900,555	0.188350	458,361		86,332	
9.	Blood	3,777,463	8,626,140	0.437909	63,178		27,666	
10.	Blood - Administration							
11.	Intravenous Therapy	4,128,489	14,848,384	0.278043	146,949		40,858	
12.	Respiratory Therapy	5,604,778	29,865,374	0.187668	598,883		112,391	
13.	Physical Therapy	4,871,774	19,699,512	0.247304	27,928		6,907	
14.	Occupational Therapy	2,077,962	9,900,762	0.209879	22,114		4,641	
15.	Speech Pathology	669,621	4,522,652	0.148059	7,942		1,176	
16.	EKG	2,445,428	34,025,243	0.071871	117,744		8,462	
17.	EEG	1,688,732	7,723,221	0.218656	11,490		2,512	
18.	Med. / Surg. Supplies	17,521,155	85,358,827	0.205265	168,835		34,656	
19.	Drugs Charged to Patients	26,691,467	118,507,784	0.225230	703,436		158,435	
20.	Renal Dialysis	1,925,234	4,240,492	0.454012	13,991		6,352	
21.	Ambulance	4,022,481	8,214,898	0.489657				
22.	Cat Scan	3,018,805	63,173,364	0.047786	160,379		7,664	
23.	Diagnostic Ultrasound	1,396,027	17,502,345	0.079762	79,387		6,332	
24.	Cardiac Cath Lab	6,832,101	56,658,914	0.120583	133,404		16,086	
25.	Cardiac Rehab	1,599,924	1,055,094	1.516381				
26.	Diabetes Center	876,522	251,223	3.489020				
27.	Impl. Devices	25,666,015	102,102,467	0.251375				
28.	Other Ancillary	230,346	1,221,934	0.188509				
29.	Mobile Clinic	1,121,131	732,204	1.531173				
30.	Outpatient Psych	654,126	434,761	1.504565				
31.	Bariatrics	364,438	220,035	1.656273				
32.	Diagnostic Treatm. Center	3,569,730	18,688,157	0.191016	64,165		12,257	
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	810,213	1,256,635	0.644748				
44.	Emergency	18,864,229	95,456,218	0.197622	218,364		43,154	
45.	Observation	8,303,918	7,985,755	1.039841				
46.	**Total**				**4,604,073**		**1,102,429**	

* 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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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)	41,785,184	2,678,825	5,082,091	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	63,056	2,948	5,246	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	662.67	908.69	968.76	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	741			
3.	Program general inpatient routine cost (Line 1c X Line 2)	491,038			
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)	491,038			

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	15,692,512	14,224	1,103.24	79	87,156
9.	Coronary Care Unit	2,775,765	1,449	1,915.64	4	7,663
10.	NICU	6,564,988	6,347	1,034.35	651	673,362
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	1,617,319	3,166	510.84	187	95,527
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,102,429
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,457,175**

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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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	1,271,346	194,001,176	0.006553	474,871		3,112	
2.	Recovery Room							
3.	Delivery and Labor Room	334,010	13,211,003	0.025283	871,265		22,028	
4.	Anesthesiology	3,235,668	15,389,761	0.210248	53,068		11,157	
5.	Radiology - Diagnostic	26,171	60,793,320	0.000430	136,130		59	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	13,156	29,484,318	0.000446	21,019		9	
8.	Laboratory	330,884	85,900,555	0.003852	458,361		1,766	
9.	Blood	2,860	8,626,140	0.000332	63,178		21	
10.	Blood - Administration							
11.	Intravenous Therapy	429	14,848,384	0.000029	146,949		4	
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	106,519	34,025,243	0.003131	117,744		369	
17.	EEG	55,650	7,723,221	0.007206	11,490		83	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cat Scan	8,358	63,173,364	0.000132	160,379		21	
23.	Diagnostic Ultrasound							
24.	Cardiac Cath Lab	3,289	56,658,914	0.000058	133,404		8	
25.	Cardiac Rehab							
26.	Diabetes Center	5,538	251,223	0.022044				
27.	Impl. Devices							
28.	Other Ancillary							
29.	Mobile Clinic	1,414	732,204	0.001931				
30.	Outpatient Psych	5,400	434,761	0.012421				
31.	Bariatrics	76,393	220,035	0.347186				
32.	Diagnostic Treatm. Center							
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	2,400	95,456,218	0.000025	218,364		5	
45.	Observation							
46.	**Ancillary Total**						**38,642**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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	3,000	63,056	0.05	741		37	
48.	Psych	461,658	2,948	156.60				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	663,576	14,224	46.65	79		3,685	
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)**						**3,722**	
68.	**Ancillary Total (from line 46)**						**38,642**	
69.	**Total (Lines 67-68)**						**42,364**	

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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)	2,457,175	
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)	42,364	
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)	4,483	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,504,022**	
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)	4,604,073	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	409,884	
	B. Psych	1,898	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	126,300	
	F. Coronary Care Unit	7,168	
	G. NICU	993,695	
	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)**	6,143,018	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,638,996
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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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)	2,504,022	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,504,022	
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)**	**2,504,022**	

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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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)	3,638,996
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:**
15-0100	**5038**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2012 To: 06/30/2013**

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: 15-0100	**Medicaid Provider Number:** 5038
Program: Medicaid Hospital	**Period Covered by Statement:** From: 07/01/2012 To: 06/30/2013

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.	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.	Cat Scan							
23.	Diagnostic Ultrasound							
24.	Cardiac Cath Lab							
25.	Cardiac Rehab							
26.	Diabetes Center							
27.	Impl. Devices							
28.	Other Ancillary							
29.	Mobile Clinic							
30.	Outpatient Psych							
31.	Bariatrics							
32.	Diagnostic Treatm. Center							
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							
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 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:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

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	381,725	63,056	6.05	741		4,483	
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)**						**4,483**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**4,483**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2012 To: 06/30/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,475		1,475
Newborn Days	187		187
Total Inpatient Revenue	6,143,018		6,143,018
Ancillary Revenue	4,604,073		4,604,073
Routine Revenue	1,538,945		1,538,945
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
GME costs were adjusted to agree with as filed W/S B Part 1, column 25