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:** 01/01/2016	**To:** 12/31/2016	

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 01/01/2016 and ending 12/31/2016 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: 01/01/2016 To: 12/31/2016

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	136	49,776		39,684	79.73%		10,541	7.40
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	61	22,326		8,039	36.01%			
6.	Coronary Care Unit								
7.	NICU	83	30,378		30,288	99.70%			
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**	**280**	**102,480**		**78,011**	**76.12%**		**10,541**	**7.40**
23.	Observation Bed Days				4,240				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,257			1,052	8.72
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,107				
6.	Coronary Care Unit								
7.	NICU				3,811				
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**9,175**	**11.76%**		**1,052**	**8.72**

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: 01/01/2016 To: 12/31/2016

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	31,625,438	92,620,686	0.341451	4,011,722		1,369,806	
2.	Recovery Room	15,914,711	19,665,326	0.809278	344,922		279,138	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,570,769	23,225,758	0.110686	821,452		90,923	
5.	Radiology - Diagnostic	8,935,572	39,880,869	0.224057	1,383,917		310,076	
6.	Radiology - Therapeutic	1,921,091	6,892,387	0.278727	72,640		20,247	
7.	Nuclear Medicine							
8.	Laboratory	28,466,678	116,571,518	0.244199	7,264,146		1,773,897	
9.	Blood							
10.	Blood - Administration	5,149,265	18,859,755	0.273029	709,666		193,759	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,462,601	35,407,380	0.239007	5,784,381		1,382,508	
13.	Physical Therapy	9,612,345	12,808,373	0.750474	469,469		352,324	
14.	Occupational Therapy	2,194,487	6,004,014	0.365503	417,709		152,674	
15.	Speech Pathology	5,022,704	8,654,389	0.580365	182,002		105,628	
16.	EKG	2,813,058	5,538,501	0.507910	581,094		295,143	
17.	EEG	1,603,776	7,573,426	0.211764	622,915		131,911	
18.	Med. / Surg. Supplies	19,538,372	49,780,676	0.392489	4,372,047		1,715,980	
19.	Drugs Charged to Patients	47,650,293	117,467,665	0.405646	7,507,517		3,045,394	
20.	Renal Dialysis	1,829,835	2,329,160	0.785620	108,861		85,523	
21.	Ambulance	7,591,670	9,635,259	0.787905	958,844		755,478	
22.	CT Scan	236,847	13,012,508	0.018201	401,067		7,300	
23.	MRI	1,812,267	48,855,531	0.037094	1,123,119		41,661	
24.	Cardiac Cath	1,106,183	20,045,882	0.055183	185,089		10,214	
25.	Implantable Devices	16,983,983	31,772,955	0.534542	1,492,059		797,568	
26.	Home Dialysis	2,858	957,811	0.002984				
27.	Kidney Acquisition	338,840	479,410	0.706785				
28.	Liver Acquisition	1,296,080	2,144,790	0.604292				
29.	Heart Acquisition	1,580,059	2,318,757	0.681425				
30.	Lung Acquisition	919,715	1,565,660	0.587430				
31.	Other Organ Acquisit	472,088	736,097	0.641339	2,888		1,852	
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	16,366,253	16,814,340	0.973351	148,755		144,791	
44.	Emergency	21,427,901	55,077,383	0.389051	972,613		378,396	
45.	Observation	7,457,185	9,349,101	0.797637	150,978		120,426	
46.	**Total**				**40,089,872**		**13,562,617**	

* 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: 01/01/2016 To: 12/31/2016

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)	77,252,054			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	43,924			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,758.77			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,257			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,728,314			
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)	5,728,314			

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	26,006,460	8,039	3,235.04	2,107	6,816,229
9.	Coronary Care Unit					
10.	NICU	62,607,933	30,288	2,067.09	3,811	7,877,680
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)					13,562,617
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**33,984,840**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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: 01/01/2016 To: 12/31/2016

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	300,125	92,620,686	0.003240	4,011,722		12,998	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	5,418,373	23,225,758	0.233292	821,452		191,638	
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.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition	137,000	2,144,790	0.063876				
29.	Heart Acquisition	130,000	2,318,757	0.056065				
30.	Lung Acquisition	20,000	1,565,660	0.012774				
31.	Other Organ Acquisit	56,728	736,097	0.077066	2,888		223	
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	464,572	16,814,340	0.027630	148,755		4,110	
44.	Emergency	395,162	55,077,383	0.007175	972,613		6,978	
45.	Observation							
46.	**Ancillary Total**						**215,947**	

* 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: 01/01/2016 To: 12/31/2016

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.	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)**							
68.	**Ancillary Total (from line 46)**						**215,947**	
69.	**Total (Lines 67-68)**						**215,947**	

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: 01/01/2016 To: 12/31/2016

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)	33,984,840	
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)	215,947	
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)	5,781,081	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**39,981,868**	
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)	40,089,872	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	6,812,622	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	10,003,300	
	F. Coronary Care Unit		
	G. NICU	12,358,512	
	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)**	69,264,306	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		29,282,438
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: 01/01/2016 To: 12/31/2016

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)	39,981,868	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	39,981,868	
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)**	**39,981,868**	

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: 01/01/2016 To: 12/31/2016

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)	29,282,438
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 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 Charge

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 Questionnair

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
26-3301	**19018**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

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 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 Questionnair

		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: 01/01/2016 To: 12/31/2016**

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	14,125,546	92,620,686	0.152510	4,011,722		611,828	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,341,480	39,880,869	0.033637	1,383,917		46,551	
6.	Radiology - Therapeutic	1,624,538	6,892,387	0.235700	72,640		17,121	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	437,579	35,407,380	0.012358	5,784,381		71,483	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology	1,042,555	8,654,389	0.120465	182,002		21,925	
16.	EKG							
17.	EEG	925,745	7,573,426	0.122236	622,915		76,143	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	971,963	13,012,508	0.074695	401,067		29,958	
23.	MRI	971,963	48,855,531	0.019895	1,123,119		22,344	
24.	Cardiac Cath	894,473	20,045,882	0.044621	185,089		8,259	
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	13,436,181	16,814,340	0.799091	148,755		118,869	
44.	Emergency	9,244,804	55,077,383	0.167851	972,613		163,254	
45.	Observation							
46.	**Ancillary Total**						**1,187,735**	

* 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: 01/01/2016 To: 12/31/2016**

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	21,875,499	43,924	498.03	3,257		1,622,084	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	6,790,867	8,039	844.74	2,107		1,779,867	
52.	Coronary Care Unit							
53.	NICU	9,468,537	30,288	312.62	3,811		1,191,395	
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)**						**4,593,346**	
68.	**Ancillary Total (from line 46)**						**1,187,735**	
69.	**Total (Lines 67-68)**						**5,781,081**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenu

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-3301	19018
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,175		9,175
Newborn Days			
Total Inpatient Revenue	69,264,306		69,264,306
Ancillary Revenue	40,089,872		40,089,872
Routine Revenue	29,174,434		29,174,434
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

Adjusted GME costs to agree with as filed W/S B Part 1, column 25