

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 University Hospital		Medicare Provider Number: 26-0105	
Street: 3635 Vista at Grand Blvd.		Medicaid Provider Number: 19025	
City: St. Louis	State: MO	Zip: 63110	
Period Covered by Statement:	From: 06/01/2010	To: 05/31/2011	

Type of Control

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"/> Other (Specify) _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> 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 University Hospital 19025 for the cost report beginning 06/01/2010 and ending 05/31/2011 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):

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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2010 To: 05/31/2011

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	219	79,935	31,484	59,734	74.73%		13,390	5.99
2.	Psych	40	14,600	1,926	9,484	64.96%		1,689	5.62
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,110		4,110	80.43%			
6.	Coronary Care Unit								
7.	6th ICU	11	4,015		3,909	97.36%			
8.	7th ICU	15	5,475		4,048	73.94%			
9.	8th ICU	11	4,015		3,567	88.84%			
10.	5th CIU	14	5,110		4,806	94.05%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	324	118,260	33,410	89,658	75.81%		15,079	5.95
23.	Observation Bed Days				4,167				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,963			561	8.82
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				175				
6.	Coronary Care Unit								
7.	6th ICU				172				
8.	7th ICU				602				
9.	8th ICU				637				
10.	5th CIU				400				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				4,949	5.52%		561	8.82

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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2010 To: 05/31/2011

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	18,017,984	101,481,159	0.177550	3,588,843		637,199	
2.	Recovery Room	5,306,624	11,685,852	0.454107	312,933		142,105	
3.	Delivery and Labor Room							
4.	Anesthesiology	895,801	15,113,514	0.059272	577,994		34,259	
5.	Radiology - Diagnostic	18,111,979	192,192,488	0.094239	5,575,498		525,429	
6.	Radiology - Therapeutic	2,832,890	29,294,958	0.096702	135,595		13,112	
7.	Nuclear Medicine	2,291,467	3,824,325	0.599182	33,729		20,210	
8.	Laboratory	19,440,202	194,169,023	0.100120	6,101,605		610,893	
9.	Blood							
10.	Blood - Administration	4,693,911	23,555,676	0.199269	1,476,638		294,248	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,658,235	26,966,959	0.135656	2,762,699		374,777	
13.	Physical Therapy	4,282,647	11,705,634	0.365862	545,288		199,500	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,465,527	41,447,056	0.155995	901,388		140,612	
17.	EEG	1,600,065	5,699,632	0.280731	235,009		65,974	
18.	Med. / Surg. Supplies	23,521,642	105,551,153	0.222846	5,582,939		1,244,136	
19.	Drugs Charged to Patients	32,130,421	299,484,035	0.107286	20,118,802		2,158,466	
20.	Renal Dialysis	2,267,470	7,610,778	0.297929	175,027		52,146	
21.	Ambulance							
22.	Endoscopy	2,036,858	13,858,342	0.146977	182,257		26,788	
23.	PET Imaging	1,235,431	16,835,025	0.073385	73,664		5,406	
24.	Cardiac Cath	115,137	83,330	1.381699				
25.	Implantable Devices	25,946,945	80,220,236	0.323446	2,304,796		745,477	
26.	ASC	690,203	1,162,838	0.593550	753		447	
27.	Bone Marrow	562,291	559,095	1.005716	98,538		99,101	
28.	Transplant Clinic	2,723,703	1,579,587	1.724313				
29.	Kidney Acquisition	5,504,282	3,568,766	1.542349				
30.	Liver Acquisition	2,848,924	2,773,922	1.027038	92,802		95,311	
31.	Pancreas Acquisition	219,258	215,556	1.017174				
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	1,711,583	2,432,920	0.703510				
44.	Emergency	10,169,330	57,494,617	0.176874	538,784		95,297	
45.	Observation	2,908,566	4,600,725	0.632197	16,708		10,563	
46.	Total				51,432,289		7,591,456	

* 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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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)	36,185,842	7,776,728		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	63,901	9,484		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	566.28	819.98		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,963			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,677,888			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)	267.35	105.27		
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)	1,677,888			

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	6,376,996	4,110	1,551.58	175	271,527
9.	Coronary Care Unit					
10.	6th ICU	5,433,938	3,909	1,390.11	172	239,099
11.	7th ICU	6,052,938	4,048	1,495.29	602	900,165
12.	8th ICU	5,283,002	3,567	1,481.08	637	943,448
13.	5th CIU	6,287,069	4,806	1,308.17	400	523,268
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)					7,591,456
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					12,146,851

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

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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.	6th ICU						
9.	7th ICU						
10.	8th ICU						
11.	5th CIU						
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:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2010 To: 05/31/2011

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	193,452	192,192,488	0.001007	5,575,498		5,615	
6.	Radiology - Therapeutic	558,943	29,294,958	0.019080	135,595		2,587	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy							
23.	PET Imaging							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	ASC							
27.	Bone Marrow							
28.	Transplant Clinic							
29.	Kidney Acquisition							
30.	Liver Acquisition							
31.	Pancreas Acquisition							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	6,402,898	57,494,617	0.111365	538,784		60,002	
45.	Observation							
46.	Ancillary Total						68,204	

* 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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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							
48.	Psych	202,443	9,484	21.35				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	6th ICU							
54.	7th ICU							
55.	8th ICU							
56.	5th CIU							
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)						68,204	
69.	Total (Lines 67-68)						68,204	

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

Preliminary

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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)	12,146,851	
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)	68,204	
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)	1,785,755	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	14,000,810	
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)	51,432,289	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,632,368	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	503,360	
	F. Coronary Care Unit		
	G. 6th ICU	1,757,029	
	H. 7th ICU	504,580	
	I. 8th ICU	1,176,757	
	J. 5th CIU	1,825,063	
	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)	60,831,446	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		46,830,636
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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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)	14,000,810	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	14,000,810	
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)	14,000,810	

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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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)	46,830,636
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (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.	Cost Report Period ended		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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)	73,058,774	14,471,663		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)	30,068,243	11,239,761		
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)	42,990,531	3,231,902		
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)	32,417	7,558		
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)	31,484	1,926		
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)	1,365.47	1,678.04		
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)	927.55	1,487.13		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)	437.92	190.91		
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))	267.35	105.27		
7. Private room cost differential adjustment (Line 2B X Line 6)	8,417,247	202,750		
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)	36,185,842	7,776,728		
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)	566.28	819.98		

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	26-0105	Medicaid Provider Number:	19025
Program:	Medicaid Hospital	Period Covered by Statement:	From: 06/01/2010 To: 05/31/2011

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	4,060,301	101,481,159	0.040010	3,588,843		143,590	
2.	Recovery Room	300,759	11,685,852	0.025737	312,933		8,054	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,526,433	15,113,514	0.167164	577,994		96,620	
5.	Radiology - Diagnostic	2,330,909	192,192,488	0.012128	5,575,498		67,620	
6.	Radiology - Therapeutic	451,137	29,294,958	0.015400	135,595		2,088	
7.	Nuclear Medicine							
8.	Laboratory	1,654,235	194,169,023	0.008520	6,101,605		51,986	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	751,896	5,699,632	0.131920	235,009		31,002	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy							
23.	PET Imaging							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	ASC							
27.	Bone Marrow	225,601	559,095	0.403511	98,538		39,761	
28.	Transplant Clinic							
29.	Kidney Acquisition							
30.	Liver Acquisition							
31.	Pancreas Acquisition							
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	225,601	2,432,920	0.092728				
44.	Emergency	1,127,875	57,494,617	0.019617	538,784		10,569	
45.	Observation							
46.	Ancillary Total						451,290	

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

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	15,639,809	63,901	244.75	2,963		725,194	
48.	Psych	902,275	9,484	95.14				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,225,638	4,110	298.21	175		52,187	
52.	Coronary Care Unit							
53.	6th ICU	1,225,638	3,909	313.54	172		53,929	
54.	7th ICU	1,225,638	4,048	302.78	602		182,274	
55.	8th ICU	1,225,638	3,567	343.60	637		218,873	
56.	5th CIU	1,225,638	4,806	255.02	400		102,008	
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)						1,334,465	
68.	Ancillary Total (from line 46)						451,290	
69.	Total (Lines 67-68)						1,785,755	

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid Hospital	Period Covered by Statement: From: 06/01/2010 To: 05/31/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,949		4,949
Newborn Days			
Total Inpatient Revenue	60,831,446		60,831,446
Ancillary Revenue	51,432,289		51,432,289
Routine Revenue	9,399,157		9,399,157
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF page 2 Observation Room days were adjusted to W/S S-3
 BHF page 3 Costs were adjusted to as filed W/S C Pt. 1, col. 1
 BHF page 3 Total Charges agree with as filed W/S C
 GME costs were adjusted to as filed W/S B Part 1, col. 25