

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: Saint 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: 06/01/2009	To: 05/31/2010	

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	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<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)) Saint Louis University Hospital 19025 for the cost report beginning 06/01/2009 and ending 05/31/2010 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 _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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: 06/01/2009 To: 05/31/2010

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	30,804	58,020	72.58%		13,313	5.78
2.	Psych	40	14,600	1,970	8,902	60.97%		1,503	5.92
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	14	5,110		3,644	71.31%			
6.	Coronary Care Unit								
7.	6th ICU	11	4,015		3,560	88.67%			
8.	7th ICU	15	5,475		3,620	66.12%			
9.	8th ICU	11	4,015		3,520	87.67%			
10.	5th ICU	14	5,110		4,625	90.51%			
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	32,774	85,891	72.63%		14,816	5.80
23.	Observation Bed Days				2,444				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,024			493	9.27
2.	Psych								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				171				
6.	Coronary Care Unit								
7.	6th ICU				535				
8.	7th ICU				134				
9.	8th ICU				262				
10.	5th ICU				445				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				4,571	5.32%		493	9.27

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: 06/01/2009 To: 05/31/2010

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	15,485,055	91,998,360	0.168319	3,283,228		552,630	
2.	Recovery Room	4,648,669	10,440,187	0.445267	344,270		153,292	
3.	Delivery and Labor Room							
4.	Anesthesiology	512,908	13,777,818	0.037227	536,448		19,970	
5.	Radiology - Diagnostic	18,863,090	186,957,593	0.100895	5,490,702		553,984	
6.	Radiology - Therapeutic	2,976,450	26,758,730	0.111233	11,157		1,241	
7.	Nuclear Medicine	2,289,243	3,745,429	0.611210	41,312		25,250	
8.	Laboratory	18,734,092	187,497,164	0.099917	4,852,377		484,835	
9.	Blood							
10.	Blood - Administration	4,943,035	23,661,540	0.208906	997,806		208,448	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,437,479	23,615,003	0.145563	1,965,064		286,041	
13.	Physical Therapy	4,169,160	11,293,152	0.369176	536,088		197,911	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,232,467	44,694,788	0.139445	1,032,373		143,959	
17.	EEG	1,386,736	5,310,610	0.261126	176,128		45,992	
18.	Med. / Surg. Supplies	23,587,927	102,558,269	0.229995	5,499,127		1,264,772	
19.	Drugs Charged to Patients	30,574,671	284,060,937	0.107634	12,924,915		1,391,160	
20.	Renal Dialysis	2,436,605	7,771,571	0.313528	304,225		95,383	
21.	Ambulance							
22.	Endoscopy	1,979,688	14,224,685	0.139173	199,545		27,771	
23.	PET Imaging	1,640,971	16,857,325	0.097345	89,731		8,735	
24.	Bone Marrow	732,366	863,369	0.848265				
25.	Cardiac Cath	159,785	1,548,365	0.103196				
26.	Impl Dev Charges	23,011,540	74,922,810	0.307137	1,373,461		421,841	
27.	ASC	735,632	871,210	0.844380				
28.	Transplant Clinic	1,829,849	1,586,847	1.153135				
29.	Kidney Acquisition [per W/S D-6]	6,566,489	6,566,489	1.000000	68,545		68,545	
30.	Liver Acquisition [per W/S D-6]	2,860,007	2,860,007	1.000000	56,406		56,406	
31.	Pancreas Acquisition [per W/S D-6]	161,546	161,546	1.000000				
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	1,722,771	2,291,255	0.751890				
44.	Emergency	10,235,853	50,310,528	0.203453	523,029		106,412	
45.	Observation	1,645,399	3,291,910	0.499831	1,738		869	
46.	Total				40,307,675		6,115,447	

* 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: 06/01/2009 To: 05/31/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	33,848,922	7,306,982		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	60,464	8,902		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	559.82	820.82		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,024			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,692,896			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)	222.63	98.44		
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)	1,692,896			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	5,511,919	3,644	1,512.60	171	258,655
9.	Coronary Care Unit					
10.	6th ICU	4,964,938	3,560	1,394.65	535	746,138
11.	7th ICU	5,582,701	3,620	1,542.18	134	206,652
12.	8th ICU	5,005,718	3,520	1,422.08	262	372,585
13.	5th ICU	6,020,676	4,625	1,301.77	445	579,288
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)					6,115,447
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					9,971,661

**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: 06/01/2009 To: 05/31/2010

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	6th ICU						
9.	7th ICU						
10.	8th ICU						
11.	5th ICU						
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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	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)
		(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: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid-Hospital	Period Covered by Statement: From: 06/01/2009 To: 05/31/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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	191,885	186,957,593	0.001026	5,490,702		5,633	
6.	Radiology - Therapeutic	528,342	26,758,730	0.019745	11,157		220	
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.	Bone Marrow							
25.	Cardiac Cath							
26.	Impl Dev Charges							
27.	ASC							
28.	Transplant Clinic							
29.	Kidney Acquisition [per W/S D-6]							
30.	Liver Acquisition [per W/S D-6]							
31.	Pancreas Acquisition [per W/S D-6]							
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	6,406,276	50,310,528	0.127335	523,029		66,600	
45.	Observation							
46.	Ancillary Total						72,453	

* 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: 06/01/2009 To: 05/31/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	6th ICU							
54.	7th ICU							
55.	8th ICU							
56.	5th ICU							
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)						72,453	
69.	Total (Lines 67-68)						72,453	

**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: 06/01/2009 To: 05/31/2010

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)	9,971,661	
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)	72,453	
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)	1,927,003	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	11,971,117	
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)	40,307,675	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,565,178	
	B. Psych		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	473,733	
	F. Coronary Care Unit		
	G. 6th ICU	1,502,959	
	H. 7th ICU	378,918	
	I. 8th ICU	746,519	
	J. 5th ICU	1,271,389	
	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)	48,246,371	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		36,275,254
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: 06/01/2009 To: 05/31/2010

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)	11,971,117	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	11,971,117	
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	11,971,117	

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: 06/01/2009 To: 05/31/2010

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	36,275,254
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: 06/01/2009 To: 05/31/2010

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, 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 Sub II	Sub III Sub III
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 Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. 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 Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)	69,144,298	13,415,737		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)	28,203,806	10,176,753		
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)	40,940,492	3,238,984		
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)	29,660	6,932		
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)	30,804	1,970		
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)	1,329.06	1,644.15		
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)	950.90	1,468.08		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)	378.16	176.07		
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))	222.63	98.44		
7. Private room cost differential adjustment (Line 2B X Line 6)	6,857,895	193,927		
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552, W/S D-1, Part I, Line 37)	33,848,922	7,306,982		
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1)	559.82	820.82		

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: 06/01/2009 To: 05/31/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	4,658,010	91,998,360	0.050631	3,283,228		166,233	
2.	Recovery Room	344,974	10,440,187	0.033043	344,270		11,376	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,898,298	13,777,818	0.210360	536,448		112,847	
5.	Radiology - Diagnostic	2,674,414	186,957,593	0.014305	5,490,702		78,544	
6.	Radiology - Therapeutic	517,460	26,758,730	0.019338	11,157		216	
7.	Nuclear Medicine							
8.	Laboratory	1,897,353	187,497,164	0.010119	4,852,377		49,101	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	862,433	5,310,610	0.162398	176,128		28,603	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy							
23.	PET Imaging							
24.	Bone Marrow	258,730	863,369	0.299675				
25.	Cardiac Cath							
26.	Impl Dev Charges							
27.	ASC							
28.	Transplant Clinic							
29.	Kidney Acquisition [per W/S D-6]							
30.	Liver Acquisition [per W/S D-6]							
31.	Pancreas Acquisition [per W/S D-6]							
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	258,730	2,291,255	0.112921				
44.	Emergency	1,293,650	50,310,528	0.025713	523,029		13,449	
45.	Observation							
46.	Ancillary Total						460,369	

* 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: 06/01/2009 To: 05/31/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	17,942,960	60,464	296.75	3,024		897,372	
48.	Psych	1,034,920	8,902	116.26				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,406,028	3,644	385.85	171		65,980	
52.	Coronary Care Unit							
53.	6th ICU	1,406,028	3,560	394.95	535		211,298	
54.	7th ICU	1,406,028	3,620	388.41	134		52,047	
55.	8th ICU	1,406,028	3,520	399.44	262		104,653	
56.	5th ICU	1,406,028	4,625	304.01	445		135,284	
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)						1,466,634	
68.	Ancillary Total (from line 46)						460,369	
69.	Total (Lines 67-68)						1,927,003	

**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: 06/01/2009 To: 05/31/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,956	(385)	4,571
Newborn Days			
Total Inpatient Revenue	48,246,371		48,246,371
Ancillary Revenue	40,307,675		40,307,675
Routine Revenue	7,938,696		7,938,696
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
 Organ (Kidney/Liver/Pancreas) Acquisition Costs were adjusted to filed W/S B, Pt 1, Col 27.
 Organ (Kidney/Liver/Pancreas) Acquisition Charges were taken from filed W/S D-6, Pt III & IV, Line 51.
 GME Costs were adjusted to filed W/S B, Pt 1, Col 26.