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)			
[ ]	Church	[ ]	Individual	[ ]	State	[ ]	Township
[ ]	Corporation	[ ]	Partnership	[ ]	City	[ ]	Hospital District
[ ]	Other (Specify)	[XXXX]	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)

[ ]	Medicaid Hospital	[ ]	Medicaid Sub II	[ ]	DHS - Office of Rehabilitation Services
[XXXX]	Medicaid Sub I Psych	[ ]	Medicaid Sub III	[ ]	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 Hospita 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:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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								
2.	Psych				385			49	7.86
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	6th ICU								
8.	7th ICU								
9.	8th ICU								
10.	5th ICU								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**385**	**0.45%**		**49**	**7.86**

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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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				
2.	Recovery Room	4,648,669	10,440,187	0.445267	22,266		9,914	
3.	Delivery and Labor Room							
4.	Anesthesiology	512,908	13,777,818	0.037227	13,531		504	
5.	Radiology - Diagnostic	18,863,090	186,957,593	0.100895	37,539		3,787	
6.	Radiology - Therapeutic	2,976,450	26,758,730	0.111233				
7.	Nuclear Medicine	2,289,243	3,745,429	0.611210				
8.	Laboratory	18,734,092	187,497,164	0.099917	98,116		9,803	
9.	Blood							
10.	Blood - Administration	4,943,035	23,661,540	0.208906	133		28	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,437,479	23,615,003	0.145563	79		11	
13.	Physical Therapy	4,169,160	11,293,152	0.369176	12,618		4,658	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,232,467	44,694,788	0.139445	7,040		982	
17.	EEG	1,386,736	5,310,610	0.261126	2,233		583	
18.	Med. / Surg. Supplies	23,587,927	102,558,269	0.229995	5,629		1,295	
19.	Drugs Charged to Patients	30,574,671	284,060,937	0.107634	132,000		14,208	
20.	Renal Dialysis	2,436,605	7,771,571	0.313528	7,271		2,280	
21.	Ambulance							
22.	Endoscopy	1,979,688	14,224,685	0.139173	5,927		825	
23.	PET Imaging	1,640,971	16,857,325	0.097345				
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	2,526		776	
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				
30.	Liver Acquisition [per W/S D-6]	2,860,007	2,860,007	1.000000				
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	28,359		5,770	
45.	Observation	1,645,399	3,291,910	0.499831	2,457		1,228	
46.	**Total**				**377,724**		**56,652**	

* 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:		
26-0105	19025		
Program:	**Period Covered by Statement:**		
Medicaid-Psych	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)		385		
3.	Program general inpatient routine cost (Line 1c X Line 2)		316,016		
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)		316,016		

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		
9.	Coronary Care Unit					
10.	6th ICU	4,964,938	3,560	1,394.65		
11.	7th ICU	5,582,701	3,620	1,542.18		
12.	8th ICU	5,005,718	3,520	1,422.08		
13.	5th ICU	6,020,676	4,625	1,301.77		
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)					56,652
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**372,668**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	From: 06/01/2009 To: 05/31/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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	37,539		39	
6.	Radiology - Therapeutic	528,342	26,758,730	0.019745				
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	28,359		3,611	
45.	Observation							
46.	**Ancillary Total**						**3,650**	

* 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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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)**						**3,650**	
69.	**Total (Lines 67-68)**						**3,650**	

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	From: 06/01/2009 To: 05/31/2010

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)	372,668	
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)	3,650	
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)	50,964	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**427,282**	
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)	377,724	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	557,110	
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. 6th ICU		
	H. 7th ICU		
	I. 8th ICU		
	J. 5th ICU		
	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)**	934,834	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		507,552
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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	From: 06/01/2009 To: 05/31/2010

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)	427,282	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	427,282	
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)**	**427,282**	

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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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)	507,552
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	Sum of Columns 1 - 4
		to	to	to		
		(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		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
26-0105	**19025**
Program:	**Period Covered by Statement:**
Medicaid-Psych	**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:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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				
2.	Recovery Room	344,974	10,440,187	0.033043	22,266		736	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,898,298	13,777,818	0.210360	13,531		2,846	
5.	Radiology - Diagnostic	2,674,414	186,957,593	0.014305	37,539		537	
6.	Radiology - Therapeutic	517,460	26,758,730	0.019338				
7.	Nuclear Medicine							
8.	Laboratory	1,897,353	187,497,164	0.010119	98,116		993	
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	2,233		363	
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	28,359		729	
45.	Observation							
46.	**Ancillary Total**						**6,204**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the 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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	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				
48.	Psych	1,034,920	8,902	116.26	385		44,760	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,406,028	3,644	385.85				
52.	Coronary Care Unit							
53.	6th ICU	1,406,028	3,560	394.95				
54.	7th ICU	1,406,028	3,620	388.41				
55.	8th ICU	1,406,028	3,520	399.44				
56.	5th ICU	1,406,028	4,625	304.01				
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)**						**44,760**	
68.	**Ancillary Total (from line 46)**						**6,204**	
69.	**Total (Lines 67-68)**						**50,964**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid-Psych	From: 06/01/2009 To: 05/31/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	385		385
Newborn Days			
Total Inpatient Revenue	377,724	557,110	934,834
Ancillary Revenue	377,724		377,724
Routine Revenue		557,110	557,110
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.
Room & Board Charges ($557,110) were taken from filed Workpaper .