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:** Missouri	**Zip:** 63110
Period Covered by Statement:	**From:** 06/01/2011	**To:** 05/31/2012

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)	XXXX XXXX	Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

XXXX XXXX	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Saint Louis University Hospita 19025 for the cost report beginning 06/01/2011 and ending 05/31/2012 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 06/01/2011 To: 05/31/2012

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	218	79,861	30,209	58,869	73.71%		13,563	5.69
2.	Psych	40	14,640		9,561	65.31%		1,755	5.45
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,124		3,753	73.24%			
6.	Coronary Care Unit								
7.	6th ICU	11	4,012		3,478	86.69%			
8.	7th ICU	15	5,461		3,237	59.27%			
9.	8th ICU	11	4,003		3,439	85.91%			
10.	5th ICU	14	5,100		4,444	87.14%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**323**	**118,201**	**30,209**	**86,781**	**73.42%**		**15,318**	**5.67**
23.	Observation Bed Days				4,457				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,823			1,064	3.87
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				205				
6.	Coronary Care Unit								
7.	6th ICU				388				
8.	7th ICU				172				
9.	8th ICU				165				
10.	5th ICU				369				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**4,122**	**4.75%**		**1,064**	**3.87**

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 Hospital	From: 06/01/2011 To: 05/31/2012

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	18,089,143	99,575,274	0.181663	3,563,250		647,311	
2.	Recovery Room	5,331,238	12,130,377	0.439495	358,644		157,622	
3.	Delivery and Labor Room							
4.	Anesthesiology	1,451,877	15,281,487	0.095009	613,952		58,331	
5.	Radiology - Diagnostic	18,135,320	190,962,792	0.094968	5,000,075		474,847	
6.	Radiology - Therapeutic	2,795,741	25,858,347	0.108118	53,778		5,814	
7.	Nuclear Medicine	2,484,443	3,697,091	0.671999	12,520		8,413	
8.	Laboratory	22,029,733	200,641,391	0.109797	4,956,252		544,182	
9.	Blood	5,697,452	28,221,881	0.201881	1,032,837		208,510	
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,681,472	24,115,722	0.152659	1,630,710		248,943	
13.	Physical Therapy	3,902,308	11,176,489	0.349153	427,633		149,309	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,603,021	53,672,517	0.123024	855,442		105,240	
17.	EEG	1,485,161	5,237,190	0.283580	215,893		61,223	
18.	Med. / Surg. Supplies	25,242,276	110,301,141	0.228849	5,192,889		1,188,387	
19.	Drugs Charged to Patients	32,894,975	283,360,253	0.116089	11,080,429		1,286,316	
20.	Renal Dialysis	2,109,018	7,176,193	0.293891	77,161		22,677	
21.	Ambulance							
22.	Endoscopy	2,528,845	16,388,794	0.154303	237,494		36,646	
23.	PET Imaging	1,117,135	18,098,270	0.061726	123,251		7,608	
24.	Implantable Devices	23,587,993	75,472,435	0.312538	2,040,554		637,751	
25.	Bone Marrow	1,207,358	1,434,803	0.841480	6,836		5,752	
26.	Transplant Clinic	2,692,227	742,362	3.626569				
27.	Kidney Acquisition	5,891,301	6,961,358	0.846286	195		165	
28.	Liver Acquisition	3,497,656	2,575,111	1.358254				
29.	Pancreas Acquisition	166,995	164,056	1.017915				
30.	Corneal Transplant	383,041	1,122,954	0.341101				
31.	Other							
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	1,918,698	2,773,050	0.691909				
44.	Emergency	10,287,883	62,834,241	0.163731	532,053		87,114	
45.	Observation	3,226,467	5,118,399	0.630366	27,166		17,125	
46.	**Total**				**38,039,014**		**5,959,286**	

* 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 Hospital	From: 06/01/2011 To: 05/31/2012

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)	45,814,661	7,674,797		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	63,326	9,561		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	723.47	802.72		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,823			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,042,356			
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)	2,042,356			

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	5,847,539	3,753	1,558.10	205	319,411
9.	Coronary Care Unit					
10.	6th ICU	4,878,710	3,478	1,402.73	388	544,259
11.	7th ICU	5,178,942	3,237	1,599.92	172	275,186
12.	8th ICU	5,339,461	3,439	1,552.62	165	256,182
13.	5th ICU	6,210,992	4,444	1,397.61	369	515,718
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)					5,959,286
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**9,912,398**

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 Hospital	From: 06/01/2011 To: 05/31/2012

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.	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 2552-10, 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:
26-0105	19025
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 06/01/2011 To: 05/31/2012

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	199,073	190,962,792	0.001042	5,000,075		5,210	
6.	Radiology - Therapeutic	570,829	25,858,347	0.022075	53,778		1,187	
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.	Implantable Devices							
25.	Bone Marrow							
26.	Transplant Clinic							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Pancreas Acquisition							
30.	Corneal Transplant							
31.	Other							
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	6,695,510	62,834,241	0.106558	532,053		56,695	
45.	Observation							
46.	**Ancillary Total**						**63,092**	

* 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 Hospital	From: 06/01/2011 To: 05/31/2012

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.	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)**						**63,092**	
69.	**Total (Lines 67-68)**						**63,092**	

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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 Hospital	From: 06/01/2011 To: 05/31/2012

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)	9,912,398	
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)	63,092	
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)	1,885,617	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**11,861,107**	
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)	38,039,014	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,545,589	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	612,668	
	F. Coronary Care Unit		
	G. 6th ICU	1,243,730	
	H. 7th ICU	461,383	
	I. 8th ICU	467,376	
	J. 5th ICU	1,050,984	
	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)**	45,420,744	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		33,559,637
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 Hospital	From: 06/01/2011 To: 05/31/2012

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)	11,861,107	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	11,861,107	
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)**	**11,861,107**	

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 Hospital	From: 06/01/2011 To: 05/31/2012

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)	33,559,637
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

Line No.	Description	Prior Cost Reporting Period Ended to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

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

Medicare Provider Number:	**Medicaid Provider Number:**
26-0105	**19025**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 06/01/2011 To: 05/31/2012**

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number: 26-0105	**Medicaid Provider Number:** 19025
Program: Medicaid Hospital	**Period Covered by Statement:** From: 06/01/2011 To: 05/31/2012

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	5,014,802	99,575,274	0.050362	3,563,250		179,452	
2.	Recovery Room	371,487	12,130,377	0.030625	358,644		10,983	
3.	Delivery and Labor Room							
4.	Anesthesiology	3,120,335	15,281,487	0.204191	613,952		125,363	
5.	Radiology - Diagnostic	2,878,887	190,962,792	0.015076	5,000,075		75,381	
6.	Radiology - Therapeutic	557,192	25,858,347	0.021548	53,778		1,159	
7.	Nuclear Medicine							
8.	Laboratory	2,042,987	200,641,391	0.010182	4,956,252		50,465	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	928,679	5,237,190	0.177324	215,893		38,283	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy							
23.	PET Imaging							
24.	Implantable Devices							
25.	Bone Marrow	278,558	1,434,803	0.194144	6,836		1,327	
26.	Transplant Clinic							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Pancreas Acquisition							
30.	Corneal Transplant							
31.	Other							
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	278,558	2,773,050	0.100452				
44.	Emergency	1,393,018	62,834,241	0.022170	532,053		11,796	
45.	Observation							
46.	**Ancillary Total**						**494,209**	

* 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: 06/01/2011 To: 05/31/2012

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	19,316,163	63,326	305.03	2,823		861,100	
48.	Psych	1,114,384	9,561	116.56				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,513,741	3,753	403.34	205		82,685	
52.	Coronary Care Unit							
53.	6th ICU	1,513,741	3,478	435.23	388		168,869	
54.	7th ICU	1,513,741	3,237	467.64	172		80,434	
55.	8th ICU	1,513,741	3,439	440.17	165		72,628	
56.	5th ICU	1,513,741	4,444	340.63	369		125,692	
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)**						**1,391,408**	
68.	**Ancillary Total (from line 46)**						**494,209**	
69.	**Total (Lines 67-68)**						**1,885,617**	

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 Hospital	From: 06/01/2011 To: 05/31/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,122		4,122
Newborn Days			
Total Inpatient Revenue	45,420,744		45,420,744
Ancillary Revenue	38,039,014		38,039,014
Routine Revenue	7,381,730		7,381,730
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 agree with as filed W/S S-3.
BHF Page 3 - Total costs agree with as filed W/S C Part 1, column 1 with the exception of Corneal Transplant costs.
BHF Page 3 - Corneal Transplant costs were adjusted to agree with as filed W/S C Part 1, column 1 to correct a transposition error
BHF Page 3 - Total charges agree with as filed W/S C Part 1, column 8
GME costs were adjusted to agree with as filed W/S B part 1, column 25 - reclassified amount from EKG line to EEG line to correct filing error