

# 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: 06/01/2008	To: 05/31/2009	

**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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Psychiatric	<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 06/01/2008 and ending 05/31/2009 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-Psychiatric	Period Covered by Statement:	From: 06/01/2008 To: 05/31/2009

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	236	86,140	28,653	59,160	68.68%		13,779	5.70
2.	Psych	40	14,600	1,783	7,531	51.58%		1,362	5.53
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	14	5,110		3,798	74.32%			
6.	Coronary Care Unit								
7.	6th ICU	11	4,015		3,594	89.51%			
8.	7th ICU	11	4,015		3,533	88.00%			
9.	8th ICU	11	4,015		3,639	90.64%			
10.	5th ICU	14	5,110		4,845	94.81%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	<b>Total</b>	<b>337</b>	<b>123,005</b>	<b>30,436</b>	<b>86,100</b>	<b>70.00%</b>		<b>15,141</b>	<b>5.69</b>
23.	Observation Bed Days				2,491				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				217			75	2.89
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.	<b>Total</b>				<b>217</b>	<b>0.25%</b>		<b>75</b>	<b>2.89</b>

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-Psychiatric	Period Covered by Statement:	From: 06/01/2008 To: 05/31/2009

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	14,803,109	88,952,369	0.166416				
2.	Recovery Room	4,241,577	9,780,255	0.433688	41,321		17,920	
3.	Delivery and Labor Room							
4.	Anesthesiology	657,574	10,881,748	0.060429	16,797		1,015	
5.	Radiology - Diagnostic	17,901,052	190,756,209	0.093843	52,505		4,927	
6.	Radiology - Therapeutic	3,060,023	27,922,067	0.109592				
7.	Nuclear Medicine	2,159,729	4,291,943	0.503205				
8.	Laboratory	18,061,657	171,983,991	0.105019	82,527		8,667	
9.	Blood							
10.	Blood - Administration	4,785,555	23,670,628	0.202173				
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,234,996	23,926,012	0.135208	6,953		940	
13.	Physical Therapy	3,804,556	11,183,743	0.340186	6,490		2,208	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,175,450	52,667,269	0.117254	3,512		412	
17.	EEG	1,311,142	5,735,619	0.228596	4,215		964	
18.	Med. / Surg. Supplies	44,518,332	177,018,977	0.251489	26,896		6,764	
19.	Drugs Charged to Patients	28,753,889	284,099,610	0.101211	139,874		14,157	
20.	Renal Dialysis	2,426,307	7,949,281	0.305223	5,858		1,788	
21.	Ambulance							
22.	Endoscopy	1,745,711	13,337,396	0.130888				
23.	PET Imaging	1,605,308	18,205,700	0.088176				
24.	Bone Marrow	610,779	800,439	0.763055				
25.	Cardiac Cath	354,271	1,847,010	0.191808				
26.	Transplant Clinic	521,917	722,953	0.721924				
27.	Kidney Acquisition [per W/S D-6]	6,227,730	6,227,730	1.000000				
28.	Liver Acquisition [per W/S D-6]	2,465,809	2,465,809	1.000000				
29.	Heart Acquisition [per W/S D-6]							
30.	Pancreas Acquisition [per W/S D-6]	276,609	276,609	1.000000				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	2,002,571	7,454,232	0.268649				
44.	Emergency	10,363,758	45,021,584	0.230195	24,202		5,571	
45.	Observation	1,641,743	2,789,387	0.588568	1,123		661	
46.	<b>Total</b>				<b>412,273</b>		<b>65,994</b>	

\* 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-Psychiatric	Period Covered by Statement: From: 06/01/2008 To: 05/31/2009

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)	40,582,398	6,367,448		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	61,651	7,531		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	658.26	845.50		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		217		
3.	Program general inpatient routine cost (Line 1c X Line 2)		183,474		
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)		125.94		
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)		183,474		

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	5,463,667	3,798	1,438.56		
9.	Coronary Care Unit					
10.	6th ICU	4,936,890	3,594	1,373.65		
11.	7th ICU	4,840,529	3,533	1,370.09		
12.	8th ICU	4,890,168	3,639	1,343.82		
13.	5th ICU	6,122,806	4,845	1,263.74		
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)					65,994
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>249,468</b>

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

Medicare Provider Number: <b>26-0105</b>	Medicaid Provider Number: <b>19025</b>
Program: <b>Medicaid-Psychiatric</b>	Period Covered by Statement: From: <b>06/01/2008</b> To: <b>05/31/2009</b>

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)
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: <b>26-0105</b>	Medicaid Provider Number: <b>19025</b>
Program: <b>Medicaid-Psychiatric</b>	Period Covered by Statement: From: <b>06/01/2008</b> To: <b>05/31/2009</b>

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)
	<b>Inpatient Ancillary Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	47,971	190,756,209	0.000251	52,505		13	
6.	Radiology - Therapeutic	505,751	27,922,067	0.018113				
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.	Transplant Clinic							
27.	Kidney Acquisition [per W/S D-6]							
28.	Liver Acquisition [per W/S D-6]							
29.	Heart Acquisition [per W/S D-6]							
30.	Pancreas Acquisition [per W/S D-6]							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	5,835,748	45,021,584	0.129621	24,202		3,137	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>3,150</b>	

\* 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: <b>26-0105</b>	Medicaid Provider Number: <b>19025</b>
Program: <b>Medicaid-Psychiatric</b>	Period Covered by Statement: From: <b>06/01/2008</b> To: <b>05/31/2009</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						<b>3,150</b>	
69.	<b>Total (Lines 67-68)</b>						<b>3,150</b>	

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

**PRELIMINARY**

<b>Medicare Provider Number:</b> 26-0105	<b>Medicaid Provider Number:</b> 19025
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 06/01/2008 To: 05/31/2009

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)	249,468	
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)	3,150	
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)	34,217	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>286,835</b>	
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)	412,273	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	245,794	
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>658,067</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		371,232
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-Psychiatric	Period Covered by Statement: From: 06/01/2008 To: 05/31/2009

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)	286,835	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	286,835	
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>286,835</b>	

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* 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-Psychiatric	Period Covered by Statement: From: 06/01/2008 To: 05/31/2009

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)	371,232
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)
			(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  
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 06/01/2008 To: 05/31/2009

**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)		10,973,124		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)		8,089,883		
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)		2,883,241		
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)		5,748		
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)		1,783		
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)		1,617.07		
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)		1,407.43		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)		209.64		
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))		125.94		
7. Private room cost differential adjustment (Line 2B X Line 6)		224,551		
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)		6,367,448		
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)		845.50		

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-Psychiatric	Period Covered by Statement:	From: 06/01/2008 To: 05/31/2009

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	4,677,860	88,952,369	0.052588				
2.	Recovery Room	346,842	9,780,255	0.035463	41,321		1,465	
3.	Delivery and Labor Room							
4.	Anesthesiology	2,910,668	10,881,748	0.267482	16,797		4,493	
5.	Radiology - Diagnostic	2,685,771	190,756,209	0.014080	52,505		739	
6.	Radiology - Therapeutic	519,762	27,922,067	0.018615				
7.	Nuclear Medicine							
8.	Laboratory	1,746,201	171,983,991	0.010153	82,527		838	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	866,603	5,735,619	0.151091	4,215		637	
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.	Transplant Clinic							
27.	Kidney Acquisition [per W/S D-6]							
28.	Liver Acquisition [per W/S D-6]							
29.	Heart Acquisition [per W/S D-6]							
30.	Pancreas Acquisition [per W/S D-6]							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic	519,762	7,454,232	0.069727				
44.	Emergency	1,299,406	45,021,584	0.028862	24,202		699	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>8,871</b>	

\* 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-Psychiatric	Period Covered by Statement:	From: 06/01/2008 To: 05/31/2009

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	18,017,761	61,651	292.25				
48.	Psych	879,597	7,531	116.80	217		25,346	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,411,354	3,798	371.60				
52.	Coronary Care Unit							
53.	6th ICU	1,411,354	3,594	392.70				
54.	7th ICU	1,411,354	3,533	399.48				
55.	8th ICU	1,411,354	3,639	387.84				
56.	5th ICU	1,411,354	4,845	291.30				
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	<b>Routine Total (lines 47-66)</b>						<b>25,346</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>8,871</b>	
69.	<b>Total (Lines 67-68)</b>						<b>34,217</b>	

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

PRELIMINARY

Medicare Provider Number: 26-0105	Medicaid Provider Number: 19025
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 06/01/2008 To: 05/31/2009

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	217		217
Newborn Days			
Total Inpatient Revenue	412,273	245,794	658,067
Ancillary Revenue	412,273		412,273
Routine Revenue		245,794	245,794
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.

GME Costs were adjusted to filed W/S B, Pt 1, Col 26.

I/P Routin Svs Charges are from provider workpapers. -- DW (11/16/09)