

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: Barnes-Jewish Hospital		Medicare Provider Number: 26-0032	
Street: One Barnes-Jewish Hospital Plaza		Medicaid Provider Number: 19014	
City: St. Louis	State: Missouri	Zip: 63110	
Period Covered by Statement:	From: 01/01/07	To: 12/31/07	

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

Type of Hospital

<input checked="" type="checkbox"/> XXXX XXXX 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"/> XXXX XXXX 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)) Barnes-Jewish Hospital 19014 for the cost report beginning 01/01/07 and ending 12/31/07 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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

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	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	1,086	391,567	13,931	236,357	60.36%		51,382	5.29	
2.	Psychiatric Unit	61	22,265	347	14,871	66.79%		1,565	9.50	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	29	10,585		9,355	88.38%				
6.	Coronary Care Unit	15	5,475		4,388	80.15%				
7.	Surgical ICU	22	8,030		7,579	94.38%				
8.	Neuro ICU	20	7,300		6,666	91.32%				
9.	Cardiothoracic ICU	29	10,585		7,448	70.36%				
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	24	8,760		8,093	92.39%				
16.	Total	1,286	464,567	14,278	294,757	63.45%		52,947	5.41	
17.	Observation Bed Days				1,250					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				8,973			1,611	6.39	
2.	Psychiatric Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				267					
6.	Coronary Care Unit				128					
7.	Surgical ICU				327					
8.	Neuro ICU				379					
9.	Cardiothoracic ICU				222					
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				187					
16.	Total				10,483	3.56%		1,611	6.39	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.526224	7,065,228			3,717,893		
2.	Recovery Room	0.419402	464,754			194,919		
3.	Delivery and Labor Room	0.585254	700,404			409,914		
4.	Anesthesiology	0.262897	856,902			225,277		
5.	Radiology - Diagnostic	0.215353	3,843,500			827,709		
6.	Radiology - Therapeutic	0.274783	390,504			107,304		
7.	Nuclear Medicine	0.248695	146,507			36,436		
8.	Laboratory	0.134048	9,365,203			1,255,387		
9.	Blood							
10.	Blood - Administration	0.246767	4,603,589			1,136,014		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.272482	1,828,917			498,347		
13.	Physical Therapy	0.345461	368,904			127,442		
14.	Occupational Therapy	0.345342	219,950			75,958		
15.	Speech Pathology	0.489717	52,885			25,899		
16.	EKG	0.095550	913,796			87,313		
17.	EEG	0.300086	185,275			55,598		
18.	Med. / Surg. Supplies	0.473042	2,568,257			1,214,893		
19.	Drugs Charged to Patients	0.294932	10,640,151			3,138,121		
20.	Renal Dialysis	0.275501	292,536			80,594		
21.	Ambulance							
22.	HLA Lab	0.137927	101,002			13,931		
23.	CT Scan	0.053147	2,055,249			109,230		
23.01	Ultrasound	0.164487	247,880			40,773		
23.02	Cardiac Catheterization Laboratory	0.208795	1,606,339			335,396		
23.03	Endoscopy	0.263254	312,242			82,199		
23.04	Electroshock Therapy	0.603826						
23.05	O/P Psych	0.397381						
23.06	Kidney Transplant	0.483493						
23.07	Liver Transplant	0.748485	133,200			99,698		
23.08	Heart Transplant	0.848235	55,000			46,653		
23.09	Other Organ Acquisition	1.172532	172,877			202,704		
Outpatient Service Cost Centers								
24.	Clinic	1.585939	22,768			36,109		
25.	Emergency	0.392136	751,126			294,544		
26.	Observation	1.166986						
27.	Total		49,964,945			14,476,255		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 917.95	\$ 928.94	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,973			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 8,236,765	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$	\$	\$
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)	\$ 8,236,765	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,168.70	267	\$ 579,043
9.	Coronary Care Unit	\$ 1,496.67	128	\$ 191,574
10.	Surgical ICU	\$ 1,577.41	327	\$ 515,813
11.	Neuro ICU	\$ 1,392.72	379	\$ 527,841
12.	Cardiothoracic ICU	\$ 1,525.66	222	\$ 338,697
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 258.69	187	\$ 48,375
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 14,476,255
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 24,914,363

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

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (BHF Page 2, Part I, Col. 4)	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.	Psychiatric Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Neuro ICU						
10.	Cardiothoracic ICU						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
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									
6.	Radiology - Therapeutic									
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.	HLA Lab									
23.	CT Scan									
23.01	Ultrasound									
23.02	Cardiac Catheterization Laboratory									
23.03	Endoscopy									
23.04	Electroshock Therapy									
23.05	O/P Psych									
23.06	Kidney Transplant									
23.07	Liver Transplant									
23.08	Heart Transplant									
23.09	Other Organ Acquisition									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Surgical ICU									
34.	Neuro ICU									
35.	Cardiothoracic ICU									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total									

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

PRELIMINARY

Medicare Provider Number: 26-0032		Medicaid Provider Number: 19014		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/07 To: 12/31/07		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	24,914,363		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	24,914,363		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	49,964,945
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	7,297,814
	B. Psychiatric Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	483,023
	F. Coronary Care Unit	222,913
	G. Surgical ICU	604,733
	H. Neuro ICU	705,159
	I. Cardiothoracic ICU	387,974
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	78,353
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	59,744,914
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	34,830,551
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	24,914,363		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	24,914,363		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B, 3B, & 4B)			
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With HCFA Pub. 15-II, Sec. 115.2 (B)			
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	24,914,363		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

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 12)	34,830,551
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)		
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 13)					
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		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

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 (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 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 Psychiatric Unit	Sub II Sub II	Sub III Sub III
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I Psychiatric Unit	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 organized clinic cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to BHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) 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) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
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)				

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	92,705,394	176,171,032	0.526224
2.	Recovery Room	18,841,096	44,923,751	0.419402
3.	Delivery and Labor Room	10,741,433	18,353,444	0.585254
4.	Anesthesiology	13,143,816	49,996,085	0.262897
5.	Radiology - Diagnostic	49,334,005	229,084,379	0.215353
6.	Radiology - Therapeutic	26,234,410	95,473,093	0.274783
7.	Nuclear Medicine	4,651,827	18,704,948	0.248695
8.	Laboratory	51,683,816	385,563,358	0.134048
9.	Blood			
10.	Blood - Administration	29,778,151	120,673,211	0.246767
11.	Intravenous Therapy			
12.	Respiratory Therapy	11,800,562	43,307,737	0.272482
13.	Physical Therapy	6,252,214	18,098,178	0.345461
14.	Occupational Therapy	2,207,744	6,392,925	0.345342
15.	Speech Pathology	762,697	1,557,424	0.489717
16.	EKG	6,674,614	69,854,868	0.095550
17.	EEG	1,304,078	4,345,681	0.300086
18.	Med. / Surg. Supplies	183,374,649	387,650,188	0.473042
19.	Drugs Charged to Patients	98,855,585	335,181,032	0.294932
20.	Renal Dialysis	3,603,670	13,080,433	0.275501
21.	Ambulance			
22.	HLA Lab	3,233,337	23,442,449	0.137927
23.	CT Scan	7,985,317	150,249,162	0.053147
23.01	Ultrasound	3,144,774	19,118,685	0.164487
23.02	Cardiac Catheterization Laboratory	10,000,009	47,893,843	0.208795
23.03	Endoscopy	7,854,464	29,836,120	0.263254
23.04	Electroshock Therapy	549,246	909,610	0.603826
23.05	O/P Psych	1,433,753	3,608,002	0.397381
23.06	Kidney Transplant	5,307,723	10,977,870	0.483493
23.07	Liver Transplant	5,023,365	6,711,374	0.748485
23.08	Heart Transplant	1,756,458	2,070,722	0.848235
23.09	Other Organ Acquisition	4,085,443	3,484,290	1.172532
Outpatient Ancillary Centers				
24.	Clinic	27,776,426	17,514,187	1.585939
25.	Emergency	34,317,683	87,514,831	0.392136
26.	Observation	1,160,962	994,838	1.166986
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	218,110,934	237,607	917.95
28.	Psychiatric Unit	13,814,218	14,871	928.94
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	20,288,146	9,355	2,168.70
32.	Coronary Care Unit	6,567,406	4,388	1,496.67
33.	Surgical ICU	11,955,159	7,579	1,577.41
34.	Neuro ICU	9,283,865	6,666	1,392.72
35.	Cardiothoracic ICU	11,363,101	7,448	1,525.66
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	2,093,584	8,093	258.69

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

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/07 To: 12/31/07

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	10,296		10,296
Newborn Days	187		187
Total Inpatient Revenue	59,744,914		59,744,914
Ancillary Revenue	49,964,945		49,964,945
Routine Revenue	9,779,969		9,779,969
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

Included Sub Provider Observation Room Days with Psych Days on BHF Page 2, Column 4, Part I, Line 2, to calculate the per diem cost.

Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.

Illinois Medicaid Discharges came from Provider workpapers.