

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: MO	Zip: 63110	
Period Covered by Statement:	From: 01/01/2009	To: 12/31/2009	

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"/> 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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II _____	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> XXXX XXXX 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)) Barnes-Jewish Hospital 19014 for the cost report beginning 01/01/2009 and ending 12/31/2009 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:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	1,033	376,948	63,230	242,503	64.33%		53,507	5.19
2.	Psychiatric Unit	46	16,790	260	12,560	74.81%		1,421	8.84
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	29	10,585		9,742	92.04%			
6.	Coronary Care Unit	15	5,475		4,445	81.19%			
7.	Surgical ICU	24	8,760		7,743	88.39%			
8.	Neuro ICU	20	7,300		6,612	90.58%			
9.	Cardiothoracic ICU	21	7,665		6,695	87.35%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,760		7,204	82.24%			
22.	Total	1,212	442,283	63,490	297,504	67.27%		54,928	5.29
23.	Observation Bed Days				1,372				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psychiatric Unit				173			30	5.77
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
8.	Neuro ICU								
9.	Cardiothoracic ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				173	0.06%		30	5.77

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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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	73,537,519	211,078,868	0.348389				
2.	Recovery Room	25,741,100	55,889,938	0.460568				
3.	Delivery and Labor Room	10,750,868	9,691,909	1.109262	1,041		1,155	
4.	Anesthesiology	12,259,194	57,656,930	0.212623				
5.	Radiology - Diagnostic	53,213,779	273,355,502	0.194669	13,697		2,666	
6.	Radiology - Therapeutic	29,155,480	107,955,665	0.270069				
7.	Nuclear Medicine	4,660,203	17,907,005	0.260245				
8.	Laboratory	57,010,636	426,080,805	0.133802	39,336		5,263	
9.	Blood							
10.	Blood - Administration	37,835,699	147,450,640	0.256599	5,039		1,293	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,626,050	56,667,373	0.293397	427		125	
13.	Physical Therapy	6,784,637	19,091,335	0.355378	283		101	
14.	Occupational Therapy	2,383,639	6,672,206	0.357249	283		101	
15.	Speech Pathology	1,016,691	1,853,149	0.548629				
16.	EKG	8,175,972	79,910,144	0.102315	2,816		288	
17.	EEG	1,340,609	5,478,149	0.244719				
18.	Med. / Surg. Supplies	206,872,970	443,983,439	0.465947	1,146		534	
19.	Drugs Charged to Patients	120,147,594	345,618,933	0.347630	35,420		12,313	
20.	Renal Dialysis	3,981,621	15,000,585	0.265431				
21.	Ambulance							
22.	HLA Lab	5,377,670	34,648,729	0.155205				
23.	CT Scan	10,607,477	174,987,149	0.060619	6,715		407	
24.	Ultrasound	4,391,647	22,583,560	0.194462				
25.	Cardiac Cath Lab	9,784,035	52,177,299	0.187515				
26.	Endoscopy	10,687,083	34,649,266	0.308436				
27.	OB/GYN In Vitro	2,328,181	2,606,351	0.893272				
28.	O/P Psych	800,657	2,511,979	0.318736				
29.	Lung Transplant [D-6]	4,857,467	5,008,591	0.969827				
30.	Kidney Transplant [D-6]	8,036,885	12,672,507	0.634199				
31.	Liver Transplant [D-6]	5,493,759	6,342,655	0.866161				
32.	Heart Transplant [D-6]	1,710,732	1,629,322	1.049966				
33.	Pancreas Transplant [D-6]	465,516	535,356	0.869545				
34.	Other Organ Acquisition	5,105,365	4,248,544	1.201674				
35.	Electroshock Therapy	456,860	837,369	0.545590	2,700		1,473	
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	19,377,584	25,384,252	0.763370	138		105	
44.	Emergency	32,465,216	111,237,578	0.291855	26,861		7,840	
45.	Observation	1,323,565	1,051,673	1.258533				
46.	Total				135,902		33,664	

* 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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	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)	189,139,514	13,976,212		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	243,875	12,560		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	775.56	1,112.76		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		173		
3.	Program general inpatient routine cost (Line 1c X Line 2)		192,507		
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)	303.90	22.03		
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)		192,507		

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	14,671,791	9,742	1,506.03		
9.	Coronary Care Unit	7,231,021	4,445	1,626.78		
10.	Surgical ICU	12,095,215	7,743	1,562.08		
11.	Neuro ICU	9,476,703	6,612	1,433.26		
12.	Cardiothoracic ICU	12,427,430	6,695	1,856.23		
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,090,489	7,204	290.18		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					33,664
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					226,171

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-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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.	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						
11.	Other						
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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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							
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							
24.	Ultrasound							
25.	Cardiac Cath Lab							
26.	Endoscopy							
27.	OB/GYN In Vitro							
28.	O/P Psych							
29.	Lung Transplant [D-6]							
30.	Kidney Transplant [D-6]							
31.	Liver Transplant [D-6]							
32.	Heart Transplant [D-6]							
33.	Pancreas Transplant [D-6]							
34.	Other Organ Acquisition							
35.	Electroshock Therapy							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary 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 / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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.	Psychiatric Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical ICU							
54.	Neuro ICU							
55.	Cardiothoracic ICU							
56.	Other							
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)							
69.	Total (Lines 67-68)							

**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-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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)	226,171	
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)		
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)	31,178	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	257,349	
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)	135,902	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psychiatric Unit	130,176	
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	H. Neuro ICU		
	I. Cardiothoracic ICU		
	J. Other		
	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)	266,078	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		8,729
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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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)	257,349	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	257,349	
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)	257,349	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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)	8,729
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

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

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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 Psychiatric Unit	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 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 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 Psychiatric Unit	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)	196,918,994	9,290,219		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)	132,410,836	9,094,179		
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)	64,508,158	196,040		
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)	180,645	12,300		
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)	63,230	260		
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)	1,020.21	754.00		
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)	732.99	739.36		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)	287.22	14.64		
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))	303.90	22.03		
7. Private room cost differential adjustment (Line 2B X Line 6)	19,215,597	5,728		
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)	189,139,514	13,976,212		
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)	775.56	1,112.76		

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	19,195,697	211,078,868	0.090941				
2.	Recovery Room							
3.	Delivery and Labor Room	1,328,743	9,691,909	0.137098	1,041		143	
4.	Anesthesiology	7,323,535	57,656,930	0.127019				
5.	Radiology - Diagnostic	1,001,192	273,355,502	0.003663	13,697		50	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	166,865	17,907,005	0.009318				
8.	Laboratory	6,192,559	426,080,805	0.014534	39,336		572	
9.	Blood							
10.	Blood - Administration	426,434	147,450,640	0.002892	5,039		15	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	247,208	5,478,149	0.045126				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	HLA Lab							
23.	CT Scan	160,685	174,987,149	0.000918	6,715		6	
24.	Ultrasound	74,162	22,583,560	0.003284				
25.	Cardiac Cath Lab	457,335	52,177,299	0.008765				
26.	Endoscopy							
27.	OB/GYN In Vitro	346,091	2,606,351	0.132788				
28.	O/P Psych							
29.	Lung Transplant [D-6]							
30.	Kidney Transplant [D-6]							
31.	Liver Transplant [D-6]							
32.	Heart Transplant [D-6]							
33.	Pancreas Transplant [D-6]							
34.	Other Organ Acquisition							
35.	Electroshock Therapy							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic	10,283,851	25,384,252	0.405127	138		56	
44.	Emergency	10,005,742	111,237,578	0.089949	26,861		2,416	
45.	Observation							
46.	Ancillary Total						3,258	

* 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: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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	53,662,665	243,875	220.04				
48.	Psychiatric Unit	2,027,105	12,560	161.39	173		27,920	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	8,448,332	9,742	867.21				
52.	Coronary Care Unit							
53.	Surgical ICU	1,470,887	7,743	189.96				
54.	Neuro ICU	673,642	6,612	101.88				
55.	Cardiothoracic ICU	67,982	6,695	10.15				
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	37,081	7,204	5.15				
67.	Routine Total (lines 47-66)						27,920	
68.	Ancillary Total (from line 46)						3,258	
69.	Total (Lines 67-68)						31,178	

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

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	173		173
Newborn Days			
Total Inpatient Revenue	266,078		266,078
Ancillary Revenue	135,902		135,902
Routine Revenue	130,176		130,176
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- Discharges were taken from filed S-3.
- Illinois Medicaid Discharges came from Provider workpapers.
- BHF Pg 2 Costs/Charges match with filed W/S C .
- Charges for Other Organ Acquisition were from filed Cost Report by provider.
- 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.