

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"/> Other (Specify) XXXX XXXX	<input 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 checked="" type="checkbox"/> 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 01/01/2009 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-Hospital	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				10,885			2,021	6.23
2.	Psychiatric Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				472				
6.	Coronary Care Unit				159				
7.	Surgical ICU				422				
8.	Neuro ICU				473				
9.	Cardiothoracic ICU				181				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				259				
22.	Total				12,851	4.32%		2,021	6.23

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-Hospital	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	8,911,595		3,104,702	
2.	Recovery Room	25,741,100	55,889,938	0.460568	727,210		334,930	
3.	Delivery and Labor Room	10,750,868	9,691,909	1.109262	496,733		551,007	
4.	Anesthesiology	12,259,194	57,656,930	0.212623	1,143,848		243,208	
5.	Radiology - Diagnostic	53,213,779	273,355,502	0.194669	4,620,548		899,477	
6.	Radiology - Therapeutic	29,155,480	107,955,665	0.270069	591,905		159,855	
7.	Nuclear Medicine	4,660,203	17,907,005	0.260245	181,120		47,136	
8.	Laboratory	57,010,636	426,080,805	0.133802	11,408,106		1,526,427	
9.	Blood							
10.	Blood - Administration	37,835,699	147,450,640	0.256599	5,438,351		1,395,475	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,626,050	56,667,373	0.293397	2,772,434		813,424	
13.	Physical Therapy	6,784,637	19,091,335	0.355378	468,290		166,420	
14.	Occupational Therapy	2,383,639	6,672,206	0.357249	257,077		91,841	
15.	Speech Pathology	1,016,691	1,853,149	0.548629	58,606		32,153	
16.	EKG	8,175,972	79,910,144	0.102315	1,337,554		136,852	
17.	EEG	1,340,609	5,478,149	0.244719	216,490		52,979	
18.	Med. / Surg. Supplies	206,872,970	443,983,439	0.465947	3,553,100		1,655,556	
19.	Drugs Charged to Patients	120,147,594	345,618,933	0.347630	12,279,300		4,268,653	
20.	Renal Dialysis	3,981,621	15,000,585	0.265431	341,104		90,540	
21.	Ambulance							
22.	HLA Lab	5,377,670	34,648,729	0.155205	126,188		19,585	
23.	CT Scan	10,607,477	174,987,149	0.060619	2,960,707		179,475	
24.	Ultrasound	4,391,647	22,583,560	0.194462	341,196		66,350	
25.	Cardiac Cath Lab	9,784,035	52,177,299	0.187515	1,195,340		224,144	
26.	Endoscopy	10,687,083	34,649,266	0.308436	600,482		185,210	
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	78,300		75,937	
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	432,000		374,182	
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	143,931		172,958	
35.	Electroshock Therapy	456,860	837,369	0.545590				
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	43,301		33,055	
44.	Emergency	32,465,216	111,237,578	0.291855	1,365,924		398,652	
45.	Observation	1,323,565	1,051,673	1.258533				
46.	Total				62,090,740		17,300,183	

* 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-Hospital	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)	10,885			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,441,971			
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)	8,441,971			

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	472	710,846
9.	Coronary Care Unit	7,231,021	4,445	1,626.78	159	258,658
10.	Surgical ICU	12,095,215	7,743	1,562.08	422	659,198
11.	Neuro ICU	9,476,703	6,612	1,433.26	473	677,932
12.	Cardiothoracic ICU	12,427,430	6,695	1,856.23	181	335,978
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	259	75,157
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					17,300,183
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					28,459,923

**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: 01/01/2009 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-Hospital	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-Hospital	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-Hospital	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)	28,459,923	
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)	4,324,436	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	32,784,359	
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)	62,090,740	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	9,397,161	
	B. Psychiatric Unit		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	942,136	
	F. Coronary Care Unit	312,230	
	G. Surgical ICU	848,870	
	H. Neuro ICU	955,121	
	I. Cardiothoracic ICU	367,978	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	119,917	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	75,034,153	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		42,249,794
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-Hospital	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)	32,784,359	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	32,784,359	
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)	32,784,359	

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-Hospital	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)	42,249,794
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-Hospital	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-Hospital	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	8,911,595		810,429	
2.	Recovery Room							
3.	Delivery and Labor Room	1,328,743	9,691,909	0.137098	496,733		68,101	
4.	Anesthesiology	7,323,535	57,656,930	0.127019	1,143,848		145,290	
5.	Radiology - Diagnostic	1,001,192	273,355,502	0.003663	4,620,548		16,925	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	166,865	17,907,005	0.009318	181,120		1,688	
8.	Laboratory	6,192,559	426,080,805	0.014534	11,408,106		165,805	
9.	Blood							
10.	Blood - Administration	426,434	147,450,640	0.002892	5,438,351		15,728	
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	216,490		9,769	
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	2,960,707		2,718	
24.	Ultrasound	74,162	22,583,560	0.003284	341,196		1,120	
25.	Cardiac Cath Lab	457,335	52,177,299	0.008765	1,195,340		10,477	
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	43,301		17,542	
44.	Emergency	10,005,742	111,237,578	0.089949	1,365,924		122,863	
45.	Observation							
46.	Ancillary Total						1,388,455	

* 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-Hospital	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	10,885		2,395,135	
48.	Psychiatric Unit	2,027,105	12,560	161.39				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	8,448,332	9,742	867.21	472		409,323	
52.	Coronary Care Unit							
53.	Surgical ICU	1,470,887	7,743	189.96	422		80,163	
54.	Neuro ICU	673,642	6,612	101.88	473		48,189	
55.	Cardiothoracic ICU	67,982	6,695	10.15	181		1,837	
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	259		1,334	
67.	Routine Total (lines 47-66)						2,935,981	
68.	Ancillary Total (from line 46)						1,388,455	
69.	Total (Lines 67-68)						4,324,436	

**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: 01/01/2009 To: 12/31/2009

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,592		12,592
Newborn Days	259		259
Total Inpatient Revenue	75,034,153		75,034,153
Ancillary Revenue	62,090,740		62,090,740
Routine Revenue	12,943,413		12,943,413
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.