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:** 01/01/2010	**To:** 12/31/2010

Type of Control

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

Type of Hospital

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

Health Care Program

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

XXXX	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
	Medicaid Sub I		Medicaid Sub III		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 01/01/2010 and ending 12/31/2010 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:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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	1,059	386,627	62,716	247,625	64.05%		53,691	5.28
2.	Psychiatric Unit	46	16,790	221	11,617	69.19%		1,420	8.18
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	29	10,585		9,894	93.47%			
6.	Coronary Care Unit	15	5,475		4,551	83.12%			
7.	Surgical ICU	24	8,760		8,054	91.94%			
8.	Neuro ICU	20	7,300		6,581	90.15%			
9.	Cardiothoracic ICU	21	7,665		7,013	91.49%			
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		6,342	72.40%			
22.	**Total**	**1,238**	**451,962**	**62,937**	**301,677**	**66.75%**		**55,111**	**5.36**
23.	Observation Bed Days				1,113				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,399			1,983	6.01
2.	Psychiatric Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				476				
6.	Coronary Care Unit				191				
7.	Surgical ICU				360				
8.	Neuro ICU				340				
9.	Cardiothoracic ICU				150				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				275				
22.	**Total**				**12,191**	**4.04%**		**1,983**	**6.01**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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	72,439,422	227,896,088	0.317862	8,748,591		2,780,845	
2.	Recovery Room	26,857,423	59,520,642	0.451229	692,713		312,572	
3.	Delivery and Labor Room	10,188,465	10,414,813	0.978267	542,985		531,184	
4.	Anesthesiology	13,093,586	73,678,163	0.177713	1,294,478		230,046	
5.	Radiology - Diagnostic	52,643,684	295,676,182	0.178045	4,804,604		855,436	
6.	Radiology - Therapeutic	30,265,327	117,681,032	0.257181	385,785		99,217	
7.	Nuclear Medicine	4,274,899	16,270,515	0.262739	129,429		34,006	
8.	Laboratory	56,842,441	463,190,157	0.122719	11,720,287		1,438,302	
9.	Blood							
10.	Blood - Administration	38,697,438	149,873,933	0.258200	5,027,786		1,298,174	
11.	Intravenous Therapy							
12.	Respiratory Therapy	17,168,877	63,021,562	0.272429	2,274,210		619,561	
13.	Physical Therapy	6,447,804	19,249,323	0.334963	417,835		139,959	
14.	Occupational Therapy	2,256,431	6,984,458	0.323065	248,150		80,169	
15.	Speech Pathology	981,136	1,896,648	0.517300	71,050		36,754	
16.	EKG	9,089,140	88,309,278	0.102924	1,267,259		130,431	
17.	EEG	1,557,245	6,263,019	0.248641	239,203		59,476	
18.	Med. / Surg. Supplies	215,984,022	472,729,714	0.456887	3,166,873		1,446,903	
19.	Drugs Charged to Patients	119,873,831	356,896,705	0.335878	12,247,582		4,113,693	
20.	Renal Dialysis	4,222,023	16,612,867	0.254142	434,775		110,495	
21.	Ambulance							
22.	HLA Lab	4,930,803	42,260,196	0.116677	161,315		18,822	
23.	CAT Scan	9,749,330	187,313,036	0.052048	2,903,575		151,125	
24.	Ultrasound	4,506,179	25,448,184	0.177073	395,482		70,029	
25.	Cardiac Cath Lab	12,593,807	58,197,388	0.216398	1,486,505		321,677	
26.	Endoscopy	9,424,588	34,592,843	0.272443	582,952		158,821	
27.	OB/GYN In Vitro	2,423,864	2,846,604	0.851493				
28.	O/P Psych	815,689	2,773,095	0.294144				
29.	Lung Transplant [D-6]	4,341,521	4,574,182	0.949136	99,200		94,154	
30.	Kidney Transplant [D-6]	10,466,007	15,199,925	0.688556	57,500		39,592	
31.	Liver Transplant [D-6]	6,542,546	7,605,894	0.860194	266,400		229,156	
32.	Heart Transplant [D-6]	1,944,091	1,952,760	0.995561	146,400		145,750	
33.	Pancreas Transplant [D-6]	708,195	758,825	0.933278				
34.	Other Organ Acquisition	5,039,886	4,237,513	1.189350	118,163		140,537	
35.	Electroshock Therapy	427,071	775,493	0.550709				
36.	Other							
37.	Corneal Tissue Acquisition	736,510	1,413,801	0.520943				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	20,108,557	28,630,428	0.702349	50,342		35,358	
44.	Emergency	30,685,164	131,928,983	0.232588	1,447,098		336,578	
45.	Observation	1,088,013	923,448	1.178207				
46.	**Total**				**61,428,527**		**16,058,822**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:			
26-0032	19014			
Program:	**Period Covered by Statement:**			
Medicaid-Hospital	From:	01/01/2010	To:	12/31/2010

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)	192,850,416	12,018,656		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	248,738	11,617		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	775.32	1,034.57		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,399			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,062,553			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)	256.36	11.55		
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)	8,062,553			

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	14,267,356	9,894	1,442.02	476	686,402
9.	Coronary Care Unit	7,408,038	4,551	1,627.78	191	310,906
10.	Surgical ICU	12,410,404	8,054	1,540.90	360	554,724
11.	Neuro ICU	9,514,896	6,581	1,445.81	340	491,575
12.	Cardiothoracic ICU	12,560,149	7,013	1,790.98	150	268,647
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,129,538	6,342	335.78	275	92,340
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					16,058,822
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**26,525,969**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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.	CAT 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.	Corneal Tissue Acquisition							
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:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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)**							

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	26,525,969	
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)	4,158,073	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**30,684,042**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	61,428,527	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	10,172,461	
	B. Psychiatric Unit		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	1,026,621	
	F. Coronary Care Unit	411,646	
	G. Surgical ICU	800,244	
	H. Neuro ICU	764,836	
	I. Cardiothoracic ICU	336,900	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	139,975	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	75,081,210	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		44,397,168
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	30,684,042	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	30,684,042	
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)**	**30,684,042**	

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

* Line 9 DOES NOT APPLY to the Medicaid program.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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)	44,397,168
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)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

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

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

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

Medicare Provider Number:	**Medicaid Provider Number:**
26-0032	**19014**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 01/01/2010 To: 12/31/2010**

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)	225,044,518	9,526,257		
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)	155,350,582	9,343,048		
	(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)	69,693,936	183,209		
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)	186,022	11,396		
	(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)	62,716	221		
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)	1,111.26	829.00		
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)	835.12	819.85		
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)	276.14	9.15		
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))**	**256.36**	**11.55**		
7.	Private room cost differential adjustment (Line 2B X Line 6)	16,077,874	2,553		
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)	192,850,416	12,018,656		
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)**	**775.32**	**1,034.57**		

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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	19,807,713	227,896,088	0.086916	8,748,591		760,393	
2.	Recovery Room							
3.	Delivery and Labor Room	1,371,107	10,414,813	0.131650	542,985		71,484	
4.	Anesthesiology	7,557,032	73,678,163	0.102568	1,294,478		132,772	
5.	Radiology - Diagnostic	1,033,113	295,676,182	0.003494	4,804,604		16,787	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	172,186	16,270,515	0.010583	129,429		1,370	
8.	Laboratory	6,389,996	463,190,157	0.013796	11,720,287		161,693	
9.	Blood							
10.	Blood - Administration	440,030	149,873,933	0.002936	5,027,786		14,762	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	255,090	6,263,019	0.040730	239,203		9,743	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	HLA Lab							
23.	CAT Scan	165,808	187,313,036	0.000885	2,903,575		2,570	
24.	Ultrasound	76,527	25,448,184	0.003007	395,482		1,189	
25.	Cardiac Cath Lab	471,916	58,197,388	0.008109	1,486,505		12,054	
26.	Endoscopy							
27.	OB/GYN In Vitro	357,126	2,846,604	0.125457				
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.	Corneal Tissue Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	10,611,730	28,630,428	0.370645	50,342		18,659	
44.	Emergency	10,324,754	131,928,983	0.078260	1,447,098		113,250	
45.	Observation							
46.	**Ancillary Total**						**1,316,726**	

* 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:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

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	55,373,590	248,738	222.62	10,399		2,315,025	
48.	Psychiatric Unit	2,091,735	11,617	180.06				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	8,717,690	9,894	881.11	476		419,408	
52.	Coronary Care Unit							
53.	Surgical ICU	1,517,784	8,054	188.45	360		67,842	
54.	Neuro ICU	695,119	6,581	105.63	340		35,914	
55.	Cardiothoracic ICU	70,150	7,013	10.00	150		1,500	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	38,263	6,342	6.03	275		1,658	
67.	**Routine Total (lines 47-66)**						**2,841,347**	
68.	**Ancillary Total (from line 46)**						**1,316,726**	
69.	**Total (Lines 67-68)**						**4,158,073**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2010 To: 12/31/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,916		11,916
Newborn Days	275		275
Total Inpatient Revenue	75,081,210		75,081,210
Ancillary Revenue	61,428,527		61,428,527
Routine Revenue	13,652,683		13,652,683
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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.