

Hospital Statement of Cost

BHF Page 1

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 XXXX Other (Specify)	☐ Corporation	☐ County	☐ Other (Specify)

Type of Hospital

☐ XXXX 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)

☐ Medicaid Hospital	☐ Medicaid Sub II	☐ DHS - Office of Rehabilitation Services
☐ XXXX XXXX Medicaid Sub I Psychiatric	☐ 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	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								
2.	Psychiatric Unit				284			55	5.16
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				284	0.09%		55	5.16

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	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				
2.	Recovery Room	26,857,423	59,520,642	0.451229				
3.	Delivery and Labor Room	10,188,465	10,414,813	0.978267				
4.	Anesthesiology	13,093,586	73,678,163	0.177713	2,361		420	
5.	Radiology - Diagnostic	52,643,684	295,676,182	0.178045	10,789		1,921	
6.	Radiology - Therapeutic	30,265,327	117,681,032	0.257181				
7.	Nuclear Medicine	4,274,899	16,270,515	0.262739				
8.	Laboratory	56,842,441	463,190,157	0.122719	52,859		6,487	
9.	Blood							
10.	Blood - Administration	38,697,438	149,873,933	0.258200				
11.	Intravenous Therapy							
12.	Respiratory Therapy	17,168,877	63,021,562	0.272429	489		133	
13.	Physical Therapy	6,447,804	19,249,323	0.334963	541		181	
14.	Occupational Therapy	2,256,431	6,984,458	0.323065	1,052		340	
15.	Speech Pathology	981,136	1,896,648	0.517300	218		113	
16.	EKG	9,089,140	88,309,278	0.102924				
17.	EEG	1,557,245	6,263,019	0.248641				
18.	Med. / Surg. Supplies	215,984,022	472,729,714	0.456887	2,438		1,114	
19.	Drugs Charged to Patients	119,873,831	356,896,705	0.335878	41,462		13,926	
20.	Renal Dialysis	4,222,023	16,612,867	0.254142				
21.	Ambulance							
22.	HLA Lab	4,930,803	42,260,196	0.116677				
23.	CAT Scan	9,749,330	187,313,036	0.052048	3,164		165	
24.	Ultrasound	4,506,179	25,448,184	0.177073				
25.	Cardiac Cath Lab	12,593,807	58,197,388	0.216398				
26.	Endoscopy	9,424,588	34,592,843	0.272443				
27.	OB/GYN In Vitro	2,423,864	2,846,604	0.851493				
28.	O/P Psych	815,689	2,773,095	0.294144	232		68	
29.	Lung Transplant [D-6]	4,341,521	4,574,182	0.949136				
30.	Kidney Transplant [D-6]	10,466,007	15,199,925	0.688556				
31.	Liver Transplant [D-6]	6,542,546	7,605,894	0.860194				
32.	Heart Transplant [D-6]	1,944,091	1,952,760	0.995561				
33.	Pancreas Transplant [D-6]	708,195	758,825	0.933278				
34.	Other Organ Acquisition	5,039,886	4,237,513	1.189350				
35.	Electroshock Therapy	427,071	775,493	0.550709	2,376		1,308	
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				
44.	Emergency	30,685,164	131,928,983	0.232588	59,208		13,771	
45.	Observation	1,088,013	923,448	1.178207				
46.	Total				177,189		39,947	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: 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)		284		
3.	Program general inpatient routine cost (Line 1c X Line 2)		293,818		
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)		293,818		

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		
9.	Coronary Care Unit	7,408,038	4,551	1,627.78		
10.	Surgical ICU	12,410,404	8,054	1,540.90		
11.	Neuro ICU	9,514,896	6,581	1,445.81		
12.	Cardiothoracic ICU	12,560,149	7,013	1,790.98		
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		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					39,947
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					333,765

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

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)	
		(1)	(2)	(3)	(4)	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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	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)							

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

BHF Page 7

PRELIMINARY

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

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)		333,765	
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)		56,783	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		390,548	
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)		177,189	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics			
B. Psychiatric Unit		245,597	
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)		422,786	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			32,238
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

BHF Page 8

PRELIMINARY

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

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)	390,548	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	390,548	
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)	390,548	

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

BHF Page 9

PRELIMINARY

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid-Psychiatric	Period Covered by Statement:	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)	32,238
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
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: 01/01/2010 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

1.		Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
	(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: 26-0032		Medicaid Provider Number: 19014	
Program: Medicaid-Psychiatric		Period Covered by Statement: 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				
2.	Recovery Room							
3.	Delivery and Labor Room	1,371,107	10,414,813	0.131650				
4.	Anesthesiology	7,557,032	73,678,163	0.102568	2,361		242	
5.	Radiology - Diagnostic	1,033,113	295,676,182	0.003494	10,789		38	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	172,186	16,270,515	0.010583				
8.	Laboratory	6,389,996	463,190,157	0.013796	52,859		729	
9.	Blood							
10.	Blood - Administration	440,030	149,873,933	0.002936				
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				
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	3,164		3	
24.	Ultrasound	76,527	25,448,184	0.003007				
25.	Cardiac Cath Lab	471,916	58,197,388	0.008109				
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				
44.	Emergency	10,324,754	131,928,983	0.078260	59,208		4,634	
45.	Observation							
46.	Ancillary Total						5,646	

* 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: 01/01/2010 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				
48.	Psychiatric Unit	2,091,735	11,617	180.06	284		51,137	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	8,717,690	9,894	881.11				
52.	Coronary Care Unit							
53.	Surgical ICU	1,517,784	8,054	188.45				
54.	Neuro ICU	695,119	6,581	105.63				
55.	Cardiothoracic ICU	70,150	7,013	10.00				
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				
67.	Routine Total (lines 47-66)						51,137	
68.	Ancillary Total (from line 46)						5,646	
69.	Total (Lines 67-68)						56,783	

PRELIMINARY

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	284		284
Newborn Days			
Total Inpatient Revenue	422,786		422,786
Ancillary Revenue	177,189		177,189
Routine Revenue	245,597		245,597
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.