

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: Missouri	Zip: 63110
Period Covered by Statement:	From: 01/01/2012	To: 12/31/2012

Type of Control

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

☐ XXXX XXXX Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ 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 01/01/2012 and ending 12/31/2012 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

Firm

Telephone Number

Email Address

Name (Typewritten)

Title

Date

Telephone Number

Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). 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 Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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	1,076	397,084	76,382	258,927	65.21%		54,836	5.38
2.	Psych	46	16,836	203	13,099	77.80%		1,625	8.06
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	29	10,614		9,732	91.69%			
6.	Coronary Care Unit	15	5,490		4,687	85.37%			
7.	SICU	36	9,864		8,446	85.62%			
8.	Neuro-ICU	20	7,320		6,326	86.42%			
9.	Cardio-Thoracic ICU	21	7,686		7,064	91.91%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,784		6,656	75.77%			
22.	Total	1,267	463,678	76,585	314,937	67.92%		56,461	5.46
23.	Observation Bed Days				2,055				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics			2,949	10,335			2,069	5.69
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				432				
6.	Coronary Care Unit				123				
7.	SICU				351				
8.	Neuro-ICU				170				
9.	Cardio-Thoracic ICU				371				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				266				
22.	Total			2,949	12,048	3.83%		2,069	5.69

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:		Medicaid Provider Number:	
26-0032		19014	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2012	To: 12/31/2012

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, 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	92,311,172	311,994,381	0.295874	6,708,153		1,984,768	
2.	Recovery Room	27,372,305	71,560,702	0.382505	869,284		332,505	
3.	Delivery and Labor Room	11,693,900	11,110,610	1.052498	466,225		490,701	
4.	Anesthesiology	12,362,490	107,424,218	0.115081	1,864,270		214,542	
5.	Radiology - Diagnostic	46,016,323	205,842,116	0.223552	3,046,191		680,982	
6.	Radiology - Therapeutic	33,053,619	155,630,237	0.212386	570,690		121,207	
7.	Nuclear Medicine	4,892,494	16,931,842	0.288952	141,323		40,836	
8.	Laboratory	64,802,609	545,752,608	0.118740	12,888,942		1,530,433	
9.	Blood							
10.	Blood - Administration	46,551,015	179,860,354	0.258818	4,885,651		1,264,494	
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,644,480	61,438,035	0.319745	2,542,385		812,915	
13.	Physical Therapy	8,303,206	23,374,726	0.355222	445,180		158,138	
14.	Occupational Therapy	2,761,854	7,858,376	0.351454	234,238		82,324	
15.	Speech Pathology	1,136,814	2,451,265	0.463766	89,588		41,548	
16.	EKG	10,296,856	103,367,728	0.099614	1,418,070		141,260	
17.	EEG	1,691,312	10,295,360	0.164279	265,793		43,664	
18.	Med. / Surg. Supplies	108,838,094	275,618,507	0.394887	7,386,329		2,916,765	
19.	Drugs Charged to Patients	145,833,503	398,754,915	0.365722	11,626,641		4,252,118	
20.	Renal Dialysis	4,926,220	20,455,072	0.240831	684,744		164,908	
21.	Ambulance							
22.	Ultrasound	5,291,541	34,273,401	0.154392	433,102		66,867	
23.	CT Scan	9,495,805	197,195,937	0.048154	2,757,802		132,799	
24.	MRI	12,879,679	136,826,930	0.094131	1,373,097		129,251	
25.	Cardiac Cath	13,751,702	60,171,778	0.228541	466,157		106,536	
26.	HLA Lab	4,957,895	37,754,735	0.131318	231,683		30,424	
27.	Endoscopy	10,479,968	40,953,976	0.255896	445,932		114,112	
28.	OB/GYN In Vitro	2,651,343	3,257,901	0.813819				
29.	Electroshock Therapy	565,988	1,596,202	0.354584	1,558		552	
30.	Corneal Tissue Acquis.	589,448	1,214,355	0.485400				
31.	Outpatient Psych	890,112	2,608,711	0.341208				
32.	Kidney Acquisition	10,709,732	14,696,725	0.728716				
33.	Heart Acquisition	2,381,406	2,198,837	1.083030	256,400		277,689	
34.	Liver Acquisition	6,016,933	6,649,339	0.904892	496,800		449,550	
35.	Lung Acquisition	5,309,157	5,588,943	0.949939	99,200		94,234	
36.	Pancreas Acquisition	856,769	1,008,817	0.849281				
37.	Other Organ Acquis.	6,633,279	5,030,787	1.318537	132,905		175,240	
38.	Implantable Devices	122,238,887	256,410,389	0.476731	3,494,207		1,665,797	
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	23,407,644	39,694,263	0.589698	62,817		37,043	
44.	Emergency	35,161,293	154,307,170	0.227866	2,201,083		501,552	
45.	Observation	1,988,213	1,477,963	1.345239	2,442		3,285	
46.	Total				68,588,882		19,059,039	

* 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 Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	252,499,672	13,860,542		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	260,982	13,099		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	967.50	1,058.14		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,335			
3.	Program general inpatient routine cost (Line 1c X Line 2)	9,999,113			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)	2,949			
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)	9,999,113			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	15,055,429	9,732	1,547.00	432	668,304
9.	Coronary Care Unit	7,798,861	4,687	1,663.93	123	204,663
10.	SICU	15,161,852	8,446	1,795.15	351	630,098
11.	Neuro-ICU	10,289,453	6,326	1,626.53	170	276,510
12.	Cardio-Thoracic ICU	13,266,952	7,064	1,878.11	371	696,779
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,425,257	6,656	364.37	266	96,922
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					19,059,039
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					31,631,428

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: 01/01/2012 To: 12/31/2012

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	SICU						
9.	Neuro-ICU						
10.	Cardio-Thoracic 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 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	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 Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, 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.	Ultrasound							
23.	CT Scan							
24.	MRI							
25.	Cardiac Cath							
26.	HLA Lab							
27.	Endoscopy							
28.	OB/GYN In Vitro							
29.	Electroshock Therapy							
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych							
32.	Kidney Acquisition							
33.	Heart Acquisition							
34.	Liver Acquisition							
35.	Lung Acquisition							
36.	Pancreas Acquisition							
37.	Other Organ Acquis.							
38.	Implantable Devices							
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 Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	SICU							
54.	Neuro-ICU							
55.	Cardio-Thoracic 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 Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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)		31,631,428	
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)		3,888,276	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		35,519,704	
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)		68,588,882	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		11,910,978	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		1,089,454	
F. Coronary Care Unit		319,185	
G. SICU		889,792	
H. Neuro-ICU		435,960	
I. Cardio-Thoracic ICU		939,390	
J. Other			
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		143,640	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		84,317,281	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			48,797,577
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 Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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)	35,519,704	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	35,519,704	
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, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	35,519,704	

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 Hospital	Period Covered by Statement:	From: 01/01/2012 To: 12/31/2012

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 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	48,797,577
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 Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

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 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
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 Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(A)	General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B)	Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C)	Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
(A)	Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B)	Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

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: 01/01/2012 To: 12/31/2012

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, 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	21,167,308	311,994,381	0.067845	6,708,153		455,115	
2.	Recovery Room							
3.	Delivery and Labor Room	1,465,219	11,110,610	0.131876	466,225		61,484	
4.	Anesthesiology	8,075,744	107,424,218	0.075176	1,864,270		140,148	
5.	Radiology - Diagnostic	1,104,026	205,842,116	0.005363	3,046,191		16,337	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	184,004	16,931,842	0.010867	141,323		1,536	
8.	Laboratory	6,828,604	545,752,608	0.012512	12,888,942		161,266	
9.	Blood							
10.	Blood - Administration	470,233	179,860,354	0.002614	4,885,651		12,771	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	272,599	10,295,360	0.026478	265,793		7,038	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound	81,780	34,273,401	0.002386	433,102		1,033	
23.	CT Scan	177,189	197,195,937	0.000899	2,757,802		2,479	
24.	MRI							
25.	Cardiac Cath	504,308	60,171,778	0.008381	466,157		3,907	
26.	HLA Lab							
27.	Endoscopy							
28.	OB/GYN In Vitro	381,639	3,257,901	0.117143				
29.	Electroshock Therapy							
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych							
32.	Kidney Acquisition							
33.	Heart Acquisition							
34.	Liver Acquisition							
35.	Lung Acquisition							
36.	Pancreas Acquisition							
37.	Other Organ Acquis.							
38.	Implantable Devices							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	11,340,116	39,694,263	0.285687	62,817		17,946	
44.	Emergency	11,033,443	154,307,170	0.071503	2,201,083		157,384	
45.	Observation							
46.	Ancillary Total						1,038,444	

* 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: 01/01/2012 To: 12/31/2012

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	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	59,174,417	260,982	226.74	10,335		2,343,358	
48.	Psych	2,235,311	13,099	170.65				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	9,316,069	9,732	957.26	432		413,536	
52.	Coronary Care Unit							
53.	SICU	1,621,964	8,446	192.04	351		67,406	
54.	Neuro-ICU	742,832	6,326	117.43	170		19,963	
55.	Cardio-Thoracic ICU	74,965	7,064	10.61	371		3,936	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	40,890	6,656	6.14	266		1,633	
67.	Routine Total (lines 47-66)						2,849,832	
68.	Ancillary Total (from line 46)						1,038,444	
69.	Total (Lines 67-68)						3,888,276	

Preliminary

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,782		11,782
Newborn Days	266		266
Total Inpatient Revenue	84,319,281	(2,000)	84,317,281
Ancillary Revenue	68,588,882		68,588,882
Routine Revenue	15,730,399	(2,000)	15,728,399
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]