

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: 01/01/2014	To: 12/31/2014	

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)

☐ 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 01/01/2014 and ending 12/31/2014 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

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: 01/01/2014 To: 12/31/2014

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	1,055	389,820		252,477	64.77%		53,887	5.42
2.	Psych	46	16,790		13,019	77.54%		1,393	9.35
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	49	13,197		9,876	74.84%			
6.	Coronary Care Unit	15	5,475		4,721	86.23%			
7.	SICU	36	13,140		11,205	85.27%			
8.	Neuro-ICU	20	7,300		6,420	87.95%			
9.	Cardio-Thoracic ICU	21	7,665		7,295	95.17%			
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		6,547	74.74%			
22.	Total	1,266	462,147		311,560	67.42%		55,280	5.52
23.	Observation Bed Days				6,749				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,198			2,151	5.39
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				275				
6.	Coronary Care Unit				137				
7.	SICU				467				
8.	Neuro-ICU				334				
9.	Cardio-Thoracic ICU				180				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				375				
22.	Total				11,966	3.84%		2,151	5.39

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: 01/01/2014	To: 12/31/2014

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	113,495,698	334,487,846	0.339312	7,721,106		2,619,864	
2.	Recovery Room	25,943,350	90,013,105	0.288217	1,180,292		340,180	
3.	Delivery and Labor Room	11,733,115	14,014,751	0.837198	618,361		517,691	
4.	Anesthesiology	12,855,353	118,521,370	0.108464	2,270,721		246,291	
5.	Radiology - Diagnostic	47,210,716	242,035,337	0.195057	3,775,977		736,531	
6.	Radiology - Therapeutic	39,747,878	257,127,748	0.154584	639,257		98,819	
7.	Nuclear Medicine	6,369,174	16,685,578	0.381717	144,920		55,318	
8.	Laboratory	66,960,301	635,251,431	0.105408	13,861,717		1,461,136	
9.	Blood							
10.	Blood - Administration	45,350,510	196,796,299	0.230444	3,888,615		896,108	
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,956,767	62,021,536	0.321772	1,633,008		525,456	
13.	Physical Therapy	8,052,879	25,071,242	0.321200	506,497		162,687	
14.	Occupational Therapy	2,816,420	8,253,024	0.341259	267,834		91,401	
15.	Speech Pathology	1,093,136	2,902,724	0.376590	115,134		43,358	
16.	EKG	10,580,850	134,844,782	0.078467	2,115,186		165,972	
17.	EEG	1,924,037	13,475,396	0.142781	327,890		46,816	
18.	Med. / Surg. Supplies	105,603,187	272,093,412	0.388114	6,811,335		2,643,574	
19.	Drugs Charged to Patients	158,579,947	439,555,703	0.360773	10,980,489		3,961,464	
20.	Renal Dialysis	5,964,739	24,756,324	0.240938	369,195		88,953	
21.	Ambulance							
22.	Ultrasound	6,023,614	44,357,417	0.135797	503,216		68,335	
23.	CT Scan	9,618,797	201,977,419	0.047623	3,088,272		147,073	
24.	MRI	15,646,466	152,222,323	0.102787	1,733,740		178,206	
25.	Cardiac Cath	14,110,459	56,772,261	0.248545	502,131		124,802	
26.	HLA Lab	4,654,993	33,254,952	0.139979	94,851		13,277	
27.	Endoscopy	11,005,417	38,963,706	0.282453	548,299		154,869	
28.	OB/GYN In Vitro	3,248,364	4,106,080	0.791111				
29.	Electroshock Therapy	693,826	2,399,858	0.289111				
30.	Corneal Tissue Acquis.	634,597	1,368,090	0.463856				
31.	Outpatient Psych	2,691,870	3,187,060	0.844625				
32.	Kidney Acquisition	12,738,605	15,531,017	0.820204				
33.	Heart Acquisition	3,098,330	2,400,448	1.290730				
34.	Liver Acquisition	6,938,184	6,841,367	1.014152	66,600		67,543	
35.	Lung Acquisition	5,777,052	5,732,837	1.007713	198,400		199,930	
36.	Pancreas Acquisition	767,846	1,031,185	0.744625				
37.	Other Organ Acquis.	7,022,907	5,135,898	1.367416	165,475		226,273	
38.	Implantable Devices	131,387,926	262,837,262	0.499883	3,243,098		1,621,170	
39.	Hyperbatic Ox. Therapy	494,854	2,423,513	0.204189				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	26,905,484	50,711,074	0.530564	78,092		41,433	
44.	Emergency	36,528,469	189,686,362	0.192573	2,813,119		541,731	
45.	Observation	6,740,294	4,586,760	1.469511	5,918		8,697	
46.	Total				70,268,745		18,094,958	

* 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: 01/01/2014 To: 12/31/2014

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)	258,891,482	13,345,705		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	259,226	13,019		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	998.71	1,025.09		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,198			
3.	Program general inpatient routine cost (Line 1c X Line 2)	10,184,845			
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)				
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)	10,184,845			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	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	18,198,650	9,876	1,842.71	275	506,745
9.	Coronary Care Unit	7,919,813	4,721	1,677.57	137	229,827
10.	SICU	20,978,025	11,205	1,872.20	467	874,317
11.	Neuro-ICU	10,603,401	6,420	1,651.62	334	551,641
12.	Cardio-Thoracic ICU	14,639,283	7,295	2,006.76	180	361,217
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,558,318	6,547	390.76	375	146,535
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					18,094,958
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					30,950,085

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: 01/01/2014 To: 12/31/2014

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	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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.	Hyperbatic Ox. Therapy							
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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014	
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)	30,950,085	
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)	3,511,780	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	34,461,865	
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)	70,268,745	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	12,885,387	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	773,974	
	F. Coronary Care Unit	382,926	
	G. SICU	1,277,022	
	H. Neuro-ICU	964,995	
	I. Cardio-Thoracic ICU	541,712	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	223,411	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	87,318,172	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		52,856,307
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: 01/01/2014 To: 12/31/2014

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)	34,461,865	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	34,461,865	
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)	34,461,865	

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: 01/01/2014 To: 12/31/2014

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)	52,856,307
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)	(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: 01/01/2014 To: 12/31/2014

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:		Medicaid Provider Number:	
26-0032		19014	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2014	To: 12/31/2014

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	26,484,001	334,487,846	0.079178	7,721,106		611,342	
2.	Recovery Room	590,306	90,013,105	0.006558	1,180,292		7,740	
3.	Delivery and Labor Room	1,260,383	14,014,751	0.089933	618,361		55,611	
4.	Anesthesiology	13,050,550	118,521,370	0.110111	2,270,721		250,031	
5.	Radiology - Diagnostic	9,987,340	242,035,337	0.041264	3,775,977		155,812	
6.	Radiology - Therapeutic	2,281,453	257,127,748	0.008873	639,257		5,672	
7.	Nuclear Medicine	2,185,728	16,685,578	0.130995	144,920		18,984	
8.	Laboratory	9,412,988	635,251,431	0.014818	13,861,717		205,403	
9.	Blood							
10.	Blood - Administration	2,217,636	196,796,299	0.011269	3,888,615		43,821	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,132,749	62,021,536	0.018264	1,633,008		29,825	
13.	Physical Therapy	1,595,422	25,071,242	0.063636	506,497		32,231	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,356,108	134,844,782	0.010057	2,115,186		21,272	
17.	EEG	4,945,807	13,475,396	0.367025	327,890		120,344	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	239,313	24,756,324	0.009667	369,195		3,569	
21.	Ambulance							
22.	Ultrasound	1,499,696	44,357,417	0.033809	503,216		17,013	
23.	CT Scan	941,299	201,977,419	0.004660	3,088,272		14,391	
24.	MRI	3,685,424	152,222,323	0.024211	1,733,740		41,976	
25.	Cardiac Cath	2,393,133	56,772,261	0.042153	502,131		21,166	
26.	HLA Lab	191,451	33,254,952	0.005757	94,851		546	
27.	Endoscopy	2,090,002	38,963,706	0.053640	548,299		29,411	
28.	OB/GYN In Vitro	191,451	4,106,080	0.046626				
29.	Electroshock Therapy	223,359	2,399,858	0.093072				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,967,484	3,187,060	0.931104				
32.	Kidney Acquisition							
33.	Heart Acquisition							
34.	Liver Acquisition							
35.	Lung Acquisition							
36.	Pancreas Acquisition							
37.	Other Organ Acquis.							
38.	Implantable Devices							
39.	Hyperbatic Ox. Therapy							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	11,008,410	50,711,074	0.217081	78,092		16,952	
44.	Emergency	9,476,805	189,686,362	0.049960	2,813,119		140,543	
45.	Observation							
46.	Ancillary Total						1,843,655	

* 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: 01/01/2014 To: 12/31/2014

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	35,195,006	259,226	135.77	10,198		1,384,582	
48.	Psych	2,823,896	13,019	216.91				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,153,212	9,876	521.79	275		143,492	
52.	Coronary Care Unit	2,823,896	4,721	598.16	137		81,948	
53.	SICU							
54.	Neuro-ICU	1,116,795	6,420	173.96	334		58,103	
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)						1,668,125	
68.	Ancillary Total (from line 46)						1,843,655	
69.	Total (Lines 67-68)						3,511,780	

Preliminary

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,591		11,591
Newborn Days	375		375
Total Inpatient Revenue	87,318,172		87,318,172
Ancillary Revenue	70,268,745		70,268,745
Routine Revenue	17,049,427		17,049,427
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adjusted Total Adults & Peds Days to agree with W/S S-3, Line 1, Col. 8.