

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: 01/01/2016	To: 12/31/2016

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 01/01/2016 and ending 12/31/2016 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:		Medicaid Provider Number:	
26-0032		19014	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2016	To: 12/31/2016

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	1,082	397,189		253,288	63.77%		51,462	5.79
2.	Psych	96	35,136		25,083	71.39%		2,587	9.70
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	44	14,924		13,386	89.69%			
6.	Coronary Care Unit	15	5,490		4,587	83.55%			
7.	SICU	36	13,176		11,248	85.37%			
8.	Neuro-ICU	20	7,320		6,653	90.89%			
9.	Cardio-Thoracic ICU	30	10,980		8,944	81.46%			
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		6,694	76.21%			
22.	Total	1,347	492,999		329,883	66.91%		54,049	5.98
23.	Observation Bed Days				6,186				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,280			1,343	6.17
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				248				
6.	Coronary Care Unit				103				
7.	SICU				293				
8.	Neuro-ICU				240				
9.	Cardio-Thoracic ICU				123				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				161				
22.	Total				8,448	2.56%		1,343	6.17

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:	01/01/2016	To: 12/31/2016

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	128,297,222	429,141,684	0.298962	6,076,431		1,816,622	
2.	Recovery Room	28,159,020	102,138,634	0.275694	828,467		228,403	
3.	Delivery and Labor Room	14,340,700	14,832,191	0.966863	544,971		526,912	
4.	Anesthesiology	15,292,606	186,768,190	0.081880	2,668,655		218,509	
5.	Radiology - Diagnostic	54,026,493	311,566,181	0.173403	2,927,105		507,569	
6.	Radiology - Therapeutic	45,913,014	316,892,425	0.144885	235,426		34,110	
7.	Nuclear Medicine	7,023,614	15,610,501	0.449929	54,083		24,334	
8.	Laboratory	82,067,503	629,939,622	0.130278	8,499,637		1,107,316	
9.	Blood							
10.	Blood - Administration	51,328,564	248,660,525	0.206420	3,229,720		666,679	
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,471,913	57,382,009	0.356765	1,066,185		380,377	
13.	Physical Therapy	7,809,372	16,471,899	0.474103	295,593		140,142	
14.	Occupational Therapy	3,503,834	7,117,793	0.492264	136,430		67,160	
15.	Speech Pathology	1,303,573	4,200,076	0.310369	137,356		42,631	
16.	EKG	10,158,901	143,826,145	0.070633	1,558,211		110,061	
17.	EEG	2,739,173	14,291,380	0.191666	269,719		51,696	
18.	Med. / Surg. Supplies	90,509,386	195,989,380	0.461808	4,163,670		1,922,816	
19.	Drugs Charged to Patients	190,128,589	430,704,030	0.441437	7,283,938		3,215,400	
20.	Renal Dialysis	6,779,106	22,265,458	0.304467	264,292		80,468	
21.	Ambulance							
22.	Ultrasound	5,547,381	50,054,120	0.110828	490,195		54,327	
23.	CT Scan	11,526,201	266,591,674	0.043235	2,366,406		102,312	
24.	MRI	17,904,486	166,624,397	0.107454	1,223,921		131,515	
25.	Cardiac Cath	18,391,096	92,298,232	0.199257	572,922		114,159	
26.	HLA Lab	6,112,142	31,102,941	0.196513	79,962		15,714	
27.	Endoscopy	13,382,218	44,901,287	0.298036	373,319		111,263	
28.	OB/GYN In Vitro	3,595,183	6,003,975	0.598800				
29.	Electroshock Therapy	758,004	2,839,499	0.266950				
30.	Corneal Tissue Acquis.	913,818	1,124,463	0.812671	9,280		7,542	
31.	Outpatient Psych	1,618,527	1,197,023	1.352127				
32.	Kidney Acquisition	14,096,612	14,936,479	0.943771				
33.	Heart Acquisition	2,873,844	1,523,234	1.886673				
34.	Liver Acquisition	5,907,881	5,754,327	1.026685	298,800		306,773	
35.	Lung Acquisition	7,270,626	7,384,489	0.984581				
36.	Pancreas Acquisition	479,551	508,112	0.943790				
37.	Bone Marrow	12,581,999	4,215,012	2.985045	94,050		280,743	
38.	Implantable Devices	140,608,117	294,120,689	0.478063	1,201,792		574,532	
39.	Hyperbatic Ox. Therapy	353,276	1,860,823	0.189849				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	32,232,143	72,541,666	0.444326	33,821		15,028	
44.	Emergency	44,088,103	242,953,499	0.181467	2,172,826		394,296	
45.	Observation	7,150,336	5,198,157	1.375552	4,325		5,949	
46.	Total				49,161,508		13,255,358	

* 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: 01/01/2016 To: 12/31/2016

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)	299,924,549	24,065,989		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	259,474	25,083		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,155.89	959.45		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,280			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,414,879			
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)	8,414,879			

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	29,387,326	13,386	2,195.38	248	544,454
9.	Coronary Care Unit	8,381,266	4,587	1,827.18	103	188,200
10.	SICU	24,627,948	11,248	2,189.54	293	641,535
11.	Neuro-ICU	13,062,663	6,653	1,963.42	240	471,221
12.	Cardio-Thoracic ICU	19,912,672	8,944	2,226.37	123	273,844
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,971,555	6,694	443.91	161	71,470
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					13,255,358
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					23,860,961

**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: 01/01/2016 To: 12/31/2016

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:				Medicaid Provider Number:			
26-0032				19014			
Program:				Period Covered by Statement:			
Medicaid Hospital				From:	01/01/2016	To:	12/31/2016

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.	Bone Marrow							
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:		Medicaid Provider Number:	
26-0032		19014	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2016	To: 12/31/2016

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 Charge:**

BHF Page 7

Preliminary

Medicare Provider Number: 26-0032		Medicaid Provider Number: 19014	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2016 To: 12/31/2016	
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)	23,860,961	
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)	2,282,078	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	26,143,039	
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)	49,161,508	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	11,443,981	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,034,982	
	F. Coronary Care Unit	381,049	
	G. SICU	1,363,308	
	H. Neuro-ICU	880,766	
	I. Cardio-Thoracic ICU	512,469	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	136,045	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	64,914,108	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		38,771,069
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: 01/01/2016 To: 12/31/2016

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)	26,143,039	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	26,143,039	
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)	26,143,039	

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:	Medicaid Provider Number:
26-0032	19014
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charge

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)	38,771,069
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 Charge

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 Charge

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 01/01/2016 To: 12/31/2016

Part I - Apportionment of Cost for the Services of Teaching Physician

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

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(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: 01/01/2016	To: 12/31/2016

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	25,842,522	429,141,684	0.060219	6,076,431		365,917	
2.	Recovery Room	396,171	102,138,634	0.003879	828,467		3,214	
3.	Delivery and Labor Room	1,401,835	14,832,191	0.094513	544,971		51,507	
4.	Anesthesiology	6,963,463	186,768,190	0.037284	2,668,655		99,498	
5.	Radiology - Diagnostic	12,311,767	311,566,181	0.039516	2,927,105		115,667	
6.	Radiology - Therapeutic	2,148,464	316,892,425	0.006780	235,426		1,596	
7.	Nuclear Medicine	2,316,075	15,610,501	0.148366	54,083		8,024	
8.	Laboratory	8,715,756	629,939,622	0.013836	8,499,637		117,601	
9.	Blood							
10.	Blood - Administration	2,392,262	248,660,525	0.009621	3,229,720		31,073	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,340,886	57,382,009	0.023368	1,066,185		24,915	
13.	Physical Therapy	1,782,768	16,471,899	0.108231	295,593		31,992	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,188,512	143,826,145	0.008264	1,558,211		12,877	
17.	EEG	4,327,403	14,291,380	0.302798	269,719		81,670	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	563,781	22,265,458	0.025321	264,292		6,692	
21.	Ambulance							
22.	Ultrasound	1,950,379	50,054,120	0.038965	490,195		19,100	
23.	CT Scan	853,291	266,591,674	0.003201	2,366,406		7,575	
24.	MRI	380,933	166,624,397	0.002286	1,223,921		2,798	
25.	Cardiac Cath	1,889,430	92,298,232	0.020471	572,922		11,728	
26.	HLA Lab							
27.	Endoscopy	2,178,939	44,901,287	0.048527	373,319		18,116	
28.	OB/GYN In Vitro	213,323	6,003,975	0.035530				
29.	Electroshock Therapy	213,323	2,839,499	0.075127				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,773,195	1,197,023	2.316743				
32.	Kidney Acquisition							
33.	Heart Acquisition							
34.	Liver Acquisition							
35.	Lung Acquisition							
36.	Pancreas Acquisition							
37.	Bone Marrow							
38.	Implantable Devices							
39.	Hyperbatic Ox. Therapy							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	13,134,584	72,541,666	0.181063	33,821		6,124	
44.	Emergency	8,532,908	242,953,499	0.035122	2,172,826		76,314	
45.	Observation							
46.	Ancillary Total						1,093,998	

* 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: 01/01/2016 To: 12/31/2016

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	32,028,880	259,474	123.44	7,280		898,643	
48.	Psych	2,590,347	25,083	103.27				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,555,963	13,386	340.35	248		84,407	
52.	Coronary Care Unit	2,636,059	4,587	574.68	103		59,192	
53.	SICU	3,138,891	11,248	279.06	293		81,765	
54.	Neuro-ICU	899,003	6,653	135.13	240		32,431	
55.	Cardio-Thoracic ICU	2,300,838	8,944	257.25	123		31,642	
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)						1,188,080	
68.	Ancillary Total (from line 46)						1,093,998	
69.	Total (Lines 67-68)						2,282,078	

Preliminary

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,340	(53)	8,287
Newborn Days	161		161
Total Inpatient Revenue	64,914,108		64,914,108
Ancillary Revenue	49,161,508		49,161,508
Routine Revenue	15,752,600		15,752,600
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.

BHF Page 3 - Total costs/ total charges agree with as filed W/S C