

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: 01/01/2019	To: 12/31/2019	

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 _____	☐ _____
☐ Medicaid Sub I Psych _____	☐ Medicaid Sub III Other _____	☐ _____

**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 01/01/2019 and ending 12/31/2019 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: 01/01/2019 To: 12/31/2019

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	1,146	422,764		282,892	66.91%		52,862	6.29
2.	Psych		17,376		11,191	64.40%		1,493	7.50
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	23,704		17,447	73.60%			
6.	Coronary Care Unit	15	5,475		4,580	83.65%			
7.	SICU	36	13,140		11,039	84.01%			
8.	Neuro-ICU	38	9,802		7,675	78.30%			
9.	Cardio-Thoracic ICU	30	10,950		8,889	81.18%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	34	12,410		5,703	45.95%			
22.	Total	1,365	515,621		349,416	67.77%		54,355	6.32
23.	Observation Bed Days				5,136				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,065			475	7.54
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				188				
6.	Coronary Care Unit				30				
7.	SICU				158				
8.	Neuro-ICU				88				
9.	Cardio-Thoracic ICU				51				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				78				
22.	Total				3,658	1.05%		475	7.54

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: 01/01/2019	To: 12/31/2019

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	144,373,981	700,201,951	0.206189	3,115,474		642,376	
2.	Recovery Room	36,930,102	103,203,723	0.357837	252,357		90,303	
3.	Delivery and Labor Room	20,179,910	15,665,809	1.288150	119,361		153,755	
4.	Anesthesiology	15,731,405	198,012,155	0.079447	765,899		60,848	
5.	Radiology - Diagnostic	53,819,912	395,195,298	0.136186	1,685,414		229,530	
6.	Radiology - Therapeutic	56,766,826	428,210,820	0.132567	443,870		58,843	
7.	Nuclear Medicine	5,933,083	14,166,359	0.418815	25,703		10,765	
8.	Laboratory	98,094,247	722,605,685	0.135751	3,622,020		491,693	
9.	Blood							
10.	Blood - Administration	52,593,660	250,877,444	0.209639	1,805,311		378,464	
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,375,768	93,638,756	0.238958	635,546		151,869	
13.	Physical Therapy	8,635,492	16,833,599	0.512991	115,658		59,332	
14.	Occupational Therapy	3,971,143	10,319,164	0.384832	84,369		32,468	
15.	Speech Pathology	1,452,496	4,710,981	0.308321	51,115		15,760	
16.	EKG	9,949,233	165,956,943	0.059951	745,067		44,668	
17.	EEG	2,933,471	16,754,528	0.175085	64,693		11,327	
18.	Med. / Surg. Supplies	110,183,995	241,404,849	0.456428	1,092,966		498,860	
19.	Drugs Charged to Patients	218,641,042	571,181,216	0.382788	3,341,952		1,279,259	
20.	Renal Dialysis	6,869,883	25,052,282	0.274222	157,637		43,228	
21.	Ambulance							
22.	Ultrasound	8,394,858	50,131,210	0.167458	191,308		32,036	
23.	CT Scan	11,143,348	326,124,611	0.034169	1,432,245		48,938	
24.	MRI	13,638,682	176,613,979	0.077223	491,112		37,925	
25.	Cardiac Cath	16,402,688	151,026,989	0.108608	215,716		23,428	
26.	HLA Lab	7,811,804	40,643,180	0.192205	68,468		13,160	
27.	Endoscopy	12,831,956	54,013,937	0.237568	114,298		27,154	
28.	OB/GYN In Vitro	4,285,920	9,061,084	0.473003				
29.	Electroshock Therapy	872,523	3,641,836	0.239583				
30.	Corneal Tissue Acquis.	473,753	1,928,677	0.245636				
31.	Outpatient Psych	820,199	641,726	1.278114				
32.	Kidney Acquisition	17,618,647	21,143,903	0.833273	94,000		78,328	
33.	Heart Acquisition	5,163,279	3,162,017	1.632907				
34.	Liver Acquisition	8,044,157	8,362,427	0.961940				
35.	Lung Acquisition	10,906,074	10,086,050	1.081303				
36.	Pancreas Acquisition	618,193	714,757	0.864900				
37.	Bone Marrow	20,646,274	45,660,977	0.452165				
38.	Implantable Devices	154,581,470	360,189,324	0.429167	1,172,608		503,245	
39.	Hyperbatic Ox. Therapy	409,671	3,238,223	0.126511				
40.	Allogenic Stem Cell Aq	8,126,154	5,325,356	1.525936				
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	33,044,537	78,386,137	0.421561	12,664		5,339	
44.	Emergency	44,784,644	355,329,222	0.126037	1,824,086		229,902	
45.	Observation	6,291,703	7,144,960	0.880579				
46.	Total				23,740,917		5,252,803	

* 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: 01/01/2019 To: 12/31/2019

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)	352,839,638	12,710,523		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	288,028	11,191		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,225.02	1,135.78		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,065			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,754,686			
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)	3,754,686			

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	39,114,079	17,447	2,241.88	188	421,473
9.	Coronary Care Unit	9,370,792	4,580	2,046.02	30	61,381
10.	SICU	25,803,082	11,039	2,337.45	158	369,317
11.	Neuro-ICU	20,208,710	7,675	2,633.06	88	231,709
12.	Cardio-Thoracic ICU	22,570,958	8,889	2,539.20	51	129,499
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,459,636	5,703	957.33	78	74,672
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					5,252,803
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					10,295,540

**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: 01/01/2019 To: 12/31/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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: 01/01/2019 To: 12/31/2019

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.	Allogenic Stem Cell Aq							
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: 01/01/2019 To: 12/31/2019

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: 01/01/2019 To: 12/31/2019	
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)	10,295,540	
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)	1,010,639	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	11,306,179	
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)	23,740,917	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,627,117	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	907,709	
	F. Coronary Care Unit	156,828	
	G. SICU	821,212	
	H. Neuro-ICU	487,227	
	I. Cardio-Thoracic ICU	261,477	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	130,284	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	34,132,771	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		22,826,592
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: 01/01/2019 To: 12/31/2019

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)	11,306,179	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	11,306,179	
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)	11,306,179	

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: 01/01/2019 To: 12/31/2019

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)	22,826,592
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: 01/01/2019 To: 12/31/2019

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

	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:	26-0032	Medicaid Provider Number:	19014
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2019 To: 12/31/2019

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	30,376,189	700,201,951	0.043382	3,115,474		135,155	
2.	Recovery Room	389,438	103,203,723	0.003773	252,357		952	
3.	Delivery and Labor Room	2,602,156	15,665,809	0.166104	119,361		19,826	
4.	Anesthesiology	8,443,731	198,012,155	0.042642	765,899		32,659	
5.	Radiology - Diagnostic	12,869,166	395,195,298	0.032564	1,685,414		54,884	
6.	Radiology - Therapeutic	2,584,454	428,210,820	0.006035	443,870		2,679	
7.	Nuclear Medicine	3,204,015	14,166,359	0.226171	25,703		5,813	
8.	Laboratory	10,408,624	722,605,685	0.014404	3,622,020		52,172	
9.	Blood							
10.	Blood - Administration	1,628,560	250,877,444	0.006491	1,805,311		11,718	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,876,385	93,638,756	0.020039	635,546		12,736	
13.	Physical Therapy	1,982,595	16,833,599	0.117776	115,658		13,622	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,628,560	165,956,943	0.009813	745,067		7,311	
17.	EEG	4,885,681	16,754,528	0.291604	64,693		18,865	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	831,982	25,052,282	0.033210	157,637		5,235	
21.	Ambulance							
22.	Ultrasound	2,301,226	50,131,210	0.045904	191,308		8,782	
23.	CT Scan	1,008,999	326,124,611	0.003094	1,432,245		4,431	
24.	MRI	424,842	176,613,979	0.002405	491,112		1,181	
25.	Cardiac Cath	2,513,647	151,026,989	0.016644	215,716		3,590	
26.	HLA Lab							
27.	Endoscopy	2,637,560	54,013,937	0.048831	114,298		5,581	
28.	OB/GYN In Vitro	194,719	9,061,084	0.021490				
29.	Electroshock Therapy	230,123	3,641,836	0.063189				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,832,279	641,726	4.413533				
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.	Allogenic Stem Cell Aq							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	15,400,516	78,386,137	0.196470	12,664		2,488	
44.	Emergency	10,868,870	355,329,222	0.030588	1,824,086		55,795	
45.	Observation							
46.	Ancillary Total						455,475	

* 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: 01/01/2019 To: 12/31/2019

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	36,961,239	288,028	128.33	3,065		393,331	
48.	Psych	1,380,736	11,191	123.38				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,328,224	17,447	305.39	188		57,413	
52.	Coronary Care Unit	2,495,946	4,580	544.97	30		16,349	
53.	SICU	4,159,909	11,039	376.84	158		59,541	
54.	Neuro-ICU	1,062,105	7,675	138.39	88		12,178	
55.	Cardio-Thoracic ICU	2,849,980	8,889	320.62	51		16,352	
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)						555,164	
68.	Ancillary Total (from line 46)						455,475	
69.	Total (Lines 67-68)						1,010,639	

Preliminary

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,580		3,580
Newborn Days	78		78
Total Inpatient Revenue	34,132,771		34,132,771
Ancillary Revenue	23,740,917		23,740,917
Routine Revenue	10,391,854		10,391,854
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]