

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: 01/01/2020	To: 12/31/2020	

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 01/01/2020 and ending 12/31/2020 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: 01/01/2020 To: 12/31/2020			

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	1,067	402,567		286,665	71.21%		50,978	6.69
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	59	20,496		18,015	87.90%			
6.	Coronary Care Unit	39	5,490		5,001	91.09%			
7.	SICU	36	13,176		11,112	84.34%			
8.	Neuro-ICU	44	13,699		11,948	87.22%			
9.	Cardio-Thoracic ICU	29	10,919		8,412	77.04%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	34	12,444		5,204	41.82%			
22.	Total	1,308	478,791		346,357	72.34%		50,978	6.69
23.	Observation Bed Days				2,868				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,701			455	7.61
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				217				
6.	Coronary Care Unit				33				
7.	SICU				345				
8.	Neuro-ICU				113				
9.	Cardio-Thoracic ICU				55				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				64				
22.	Total				3,528	1.02%		455	7.61

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: 01/01/2020	To: 12/31/2020

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	146,894,158	720,955,459	0.203749	4,025,788		820,250	
2.	Recovery Room	35,316,625	101,440,714	0.348150	343,185		119,480	
3.	Delivery and Labor Room	21,951,397	18,202,351	1.205965	53,927		65,034	
4.	Anesthesiology	13,437,862	202,200,536	0.066458	1,021,337		67,876	
5.	Radiology - Diagnostic	55,209,092	375,248,909	0.147127	1,753,749		258,024	
6.	Radiology - Therapeutic	66,367,868	392,367,104	0.169147	286,951		48,537	
7.	Nuclear Medicine	5,638,710	13,797,505	0.408676	11,825		4,833	
8.	Laboratory	111,203,273	712,876,086	0.155992	3,787,094		590,756	
9.	Blood							
10.	Blood - Administration	55,710,743	268,232,691	0.207696	2,253,627		468,069	
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,383,455	115,378,955	0.193999	1,468,800		284,946	
13.	Physical Therapy	9,358,064	16,643,323	0.562271	127,573		71,731	
14.	Occupational Therapy	4,346,584	10,578,529	0.410887	89,681		36,849	
15.	Speech Pathology	1,718,749	4,762,318	0.360906	50,442		18,205	
16.	EKG	8,409,821	161,810,640	0.051973	856,484		44,514	
17.	EEG	3,596,123	18,361,274	0.195854	80,215		15,710	
18.	Med. / Surg. Supplies	105,172,884	218,522,326	0.481291	1,103,668		531,185	
19.	Drugs Charged to Patients	218,818,905	544,924,781	0.401558	2,403,379		965,096	
20.	Renal Dialysis	7,762,357	30,966,201	0.250672	320,284		80,286	
21.	Ambulance							
22.	Ultrasound	7,132,624	43,844,661	0.162679	141,695		23,051	
23.	CT Scan	10,811,318	313,544,327	0.034481	1,519,824		52,405	
24.	MRI	14,186,332	154,989,388	0.091531	520,605		47,651	
25.	Cardiac Cath	16,967,685	146,691,681	0.115669	426,879		49,377	
26.	HLA Lab	7,359,991	33,699,754	0.218399	32,548		7,108	
27.	Endoscopy	11,389,297	49,871,527	0.228373	104,601		23,888	
28.	OB/GYN In Vitro	5,123,085	7,890,510	0.649272				
29.	Electroshock Therapy	826,633	2,833,489	0.291737	23,023		6,717	
30.	Corneal Tissue Acquis.	917,230	2,467,605	0.371709				
31.	Outpatient Psych	858,315	634,520	1.352700				
32.	Kidney Acquisition	18,799,703	19,809,000	0.949049				
33.	Heart Acquisition	5,783,472	3,949,600	1.464318				
34.	Liver Acquisition	10,412,207	10,386,500	1.002475	66,600		66,765	
35.	Lung Acquisition	7,904,165	6,593,825	1.198722				
36.	Pancreas Acquisition	559,718	496,000	1.128464				
37.	Bone Marrow	22,654,883	41,776,000	0.542294				
38.	Implantable Devices	148,242,701	326,836,032	0.453569	1,459,924		662,176	
39.	Hyperbatic Ox. Therapy	207,356	1,456,239	0.142391				
40.	Allogenic Stem Cell Aq	6,664,063	3,688,728	1.806602				
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	33,572,520	65,856,604	0.509782	8,037		4,097	
44.	Emergency	42,878,568	333,933,739	0.128404	1,714,515		220,151	
45.	Observation	3,903,434	4,607,664	0.847161	5,762		4,881	
46.	Total				26,062,022		5,659,648	

* 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: 01/01/2020 To: 12/31/2020

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)	394,063,747			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	289,533			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,361.03			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,701			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,676,142			
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)	3,676,142			

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	43,819,505	18,015	2,432.39	217	527,829
9.	Coronary Care Unit	12,099,117	5,001	2,419.34	33	79,838
10.	SICU	28,010,187	11,112	2,520.72	345	869,648
11.	Neuro-ICU	30,437,297	11,948	2,547.48	113	287,865
12.	Cardio-Thoracic ICU	23,327,162	8,412	2,773.08	55	152,519
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,433,378	5,204	1,044.08	64	66,821
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					5,659,648
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					11,320,310

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: 01/01/2020 To: 12/31/2020

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: 01/01/2020 To: 12/31/2020

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: 01/01/2020 To: 12/31/2020

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: 01/01/2020 To: 12/31/2020	
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)	11,320,310	
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)	1,155,879	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	12,476,189	
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)	26,062,022	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,349,461	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,230,121	
	F. Coronary Care Unit	188,430	
	G. SICU	1,980,664	
	H. Neuro-ICU	649,232	
	I. Cardio-Thoracic ICU	311,813	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	120,320	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	37,892,063	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		25,415,874
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: 01/01/2020 To: 12/31/2020

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)	12,476,189	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	12,476,189	
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)	12,476,189	

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: 01/01/2020 To: 12/31/2020

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)	25,415,874
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: 01/01/2020 To: 12/31/2020

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:		Medicaid Provider Number:	
26-0032		19014	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2020	To: 12/31/2020

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	32,868,022	720,955,459	0.045590	4,025,788		183,536	
2.	Recovery Room	222,457	101,440,714	0.002193	343,185		753	
3.	Delivery and Labor Room	2,854,865	18,202,351	0.156840	53,927		8,458	
4.	Anesthesiology	9,417,346	202,200,536	0.046574	1,021,337		47,568	
5.	Radiology - Diagnostic	13,384,496	375,248,909	0.035668	1,753,749		62,553	
6.	Radiology - Therapeutic	2,354,337	392,367,104	0.006000	286,951		1,722	
7.	Nuclear Medicine	3,077,322	13,797,505	0.223035	11,825		2,637	
8.	Laboratory	11,030,160	712,876,086	0.015473	3,787,094		58,598	
9.	Blood							
10.	Blood - Administration	1,390,356	268,232,691	0.005183	2,253,627		11,681	
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,261,646	115,378,955	0.019602	1,468,800		28,791	
13.	Physical Therapy	2,131,880	16,643,323	0.128092	127,573		16,341	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,538,661	161,810,640	0.009509	856,484		8,144	
17.	EEG	5,524,349	18,361,274	0.300870	80,215		24,134	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	982,518	30,966,201	0.031729	320,284		10,162	
21.	Ambulance							
22.	Ultrasound	2,372,875	43,844,661	0.054120	141,695		7,669	
23.	CT Scan	963,980	313,544,327	0.003074	1,519,824		4,672	
24.	MRI	500,528	154,989,388	0.003229	520,605		1,681	
25.	Cardiac Cath	2,521,179	146,691,681	0.017187	426,879		7,337	
26.	HLA Lab	55,614	33,699,754	0.001650	32,548		54	
27.	Endoscopy	2,650,946	49,871,527	0.053156	104,601		5,560	
28.	OB/GYN In Vitro	185,381	7,890,510	0.023494				
29.	Electroshock Therapy	240,995	2,833,489	0.085052	23,023		1,958	
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,854,865	634,520	4.499251				
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	16,369,128	65,856,604	0.248557	8,037		1,998	
44.	Emergency	12,457,592	333,933,739	0.037306	1,714,515		63,962	
45.	Observation							
46.	Ancillary Total						559,969	

* 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: 01/01/2020 To: 12/31/2020

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	38,744,595	289,533	133.82	2,701		361,448	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,005,282	18,015	277.84	217		60,291	
52.	Coronary Care Unit	2,428,489	5,001	485.60	33		16,025	
53.	SICU	4,115,454	11,112	370.36	345		127,774	
54.	Neuro-ICU	1,186,437	11,948	99.30	113		11,221	
55.	Cardio-Thoracic ICU	2,929,017	8,412	348.20	55		19,151	
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)						595,910	
68.	Ancillary Total (from line 46)						559,969	
69.	Total (Lines 67-68)						1,155,879	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 26-0032	Medicaid Provider Number: 19014
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,464		3,464
Newborn Days	64		64
Total Inpatient Revenue	37,892,063		37,892,063
Ancillary Revenue	26,062,022		26,062,022
Routine Revenue	11,830,041		11,830,041
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 -Excluded Labor & Delivery days from both Part I and Part II

BHF Page 2 - total bed days / beds is 366.05 days; allowed as the information ties to W/S S-3 and the 2019 beds and bed days totaled 377 days for the year.

BHF Page 2 - no psych days reported on the cost report; no separate psych report filed; per W/S S-2 Part I line 70 this is not a IPF subprovider. On 1/31/19 the 005 ID showed separate Psych unit ended. Nondistinct psych unit under the 002 ID shows billings possibly in the A&P; immaterial so no separate listing on cost report necessary.

BHF Reconciliation - removed the Labor & Delivery days from the Adult Days line