Hospital Statement of Cost

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)

	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
XXXX XXXX	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)		Name (Typewritten)	
Title	Date	Title	
Firm		Date	
Telephone Number		Telephone Number	
Email Address		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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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								
2.	Psych				310			46	6.74
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	SICU								
8.	Neuro-ICU								
9.	Cardio-Thoracic ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**310**	**0.10%**		**46**	**6.74**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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)	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	113,495,698	334,487,846	0.339312	15,365		5,214	
2.	Recovery Room	25,943,350	90,013,105	0.288217	4,095		1,180	
3.	Delivery and Labor Room	11,733,115	14,014,751	0.837198				
4.	Anesthesiology	12,855,353	118,521,370	0.108464	33,879		3,675	
5.	Radiology - Diagnostic	47,210,716	242,035,337	0.195057	7,007		1,367	
6.	Radiology - Therapeutic	39,747,878	257,127,748	0.154584				
7.	Nuclear Medicine	6,369,174	16,685,578	0.381717				
8.	Laboratory	66,960,301	635,251,431	0.105408	86,678		9,137	
9.	Blood							
10.	Blood - Administration	45,350,510	196,796,299	0.230444	430		99	
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,956,767	62,021,536	0.321772	121		39	
13.	Physical Therapy	8,052,879	25,071,242	0.321200	278		89	
14.	Occupational Therapy	2,816,420	8,253,024	0.341259	177		60	
15.	Speech Pathology	1,093,136	2,902,724	0.376590				
16.	EKG	10,580,850	134,844,782	0.078467	1,763		138	
17.	EEG	1,924,037	13,475,396	0.142781				
18.	Med. / Surg. Supplies	105,603,187	272,093,412	0.388114	224		87	
19.	Drugs Charged to Patients	158,579,947	439,555,703	0.360773	59,722		21,546	
20.	Renal Dialysis	5,964,739	24,756,324	0.240938				
21.	Ambulance							
22.	Ultrasound	6,023,614	44,357,417	0.135797	2,012		273	
23.	CT Scan	9,618,797	201,977,419	0.047623	2,040		97	
24.	MRI	15,646,466	152,222,323	0.102787	14,761		1,517	
25.	Cardiac Cath	14,110,459	56,772,261	0.248545				
26.	HLA Lab	4,654,993	33,254,952	0.139979				
27.	Endoscopy	11,005,417	38,963,706	0.282453	2,086		589	
28.	OB/GYN In Vitro	3,248,364	4,106,080	0.791111				
29.	Electroshock Therapy	693,826	2,399,858	0.289111	23,540		6,806	
30.	Corneal Tissue Acquis.	634,597	1,368,090	0.463856				
31.	Outpatient Psych	2,691,870	3,187,060	0.844625	108		91	
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				
35.	Lung Acquisition	5,777,052	5,732,837	1.007713				
36.	Pancreas Acquisition	767,846	1,031,185	0.744625				
37.	Other Organ Acquis.	7,022,907	5,135,898	1.367416				
38.	Implantable Devices	131,387,926	262,837,262	0.499883				
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				
44.	Emergency	36,528,469	189,686,362	0.192573	95,604		18,411	
45.	Observation	6,740,294	4,586,760	1.469511				
46.	**Total**				**349,890**		**70,415**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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)		310		
3.	Program general inpatient routine cost (Line 1c X Line 2)		317,778		
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)		317,778		

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		
9.	Coronary Care Unit	7,919,813	4,721	1,677.57		
10.	SICU	20,978,025	11,205	1,872.20		
11.	Neuro-ICU	10,603,401	6,420	1,651.62		
12.	Cardio-Thoracic ICU	14,639,283	7,295	2,006.76		
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		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					70,415
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**388,193**

Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

Preliminary

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

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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)	388,193	
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)	81,447	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**469,640**	
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)	349,890	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	325,409	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. SICU		
	H. Neuro-ICU		
	I. Cardio-Thoracic ICU		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	675,299	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		205,659
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

Preliminary

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

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	469,640	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	469,640	
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)**	**469,640**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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)	205,659
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
26-0032	**19014**
Program:	**Period Covered by Statement:**
Medicaid Psych	**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

		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 Psych	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	15,365		1,217	
2.	Recovery Room	590,306	90,013,105	0.006558	4,095		27	
3.	Delivery and Labor Room	1,260,383	14,014,751	0.089933				
4.	Anesthesiology	13,050,550	118,521,370	0.110111	33,879		3,730	
5.	Radiology - Diagnostic	9,987,340	242,035,337	0.041264	7,007		289	
6.	Radiology - Therapeutic	2,281,453	257,127,748	0.008873				
7.	Nuclear Medicine	2,185,728	16,685,578	0.130995				
8.	Laboratory	9,412,988	635,251,431	0.014818	86,678		1,284	
9.	Blood							
10.	Blood - Administration	2,217,636	196,796,299	0.011269	430		5	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,132,749	62,021,536	0.018264	121		2	
13.	Physical Therapy	1,595,422	25,071,242	0.063636	278		18	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,356,108	134,844,782	0.010057	1,763		18	
17.	EEG	4,945,807	13,475,396	0.367025				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	239,313	24,756,324	0.009667				
21.	Ambulance							
22.	Ultrasound	1,499,696	44,357,417	0.033809	2,012		68	
23.	CT Scan	941,299	201,977,419	0.004660	2,040		10	
24.	MRI	3,685,424	152,222,323	0.024211	14,761		357	
25.	Cardiac Cath	2,393,133	56,772,261	0.042153				
26.	HLA Lab	191,451	33,254,952	0.005757				
27.	Endoscopy	2,090,002	38,963,706	0.053640	2,086		112	
28.	OB/GYN In Vitro	191,451	4,106,080	0.046626				
29.	Electroshock Therapy	223,359	2,399,858	0.093072	23,540		2,191	
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,967,484	3,187,060	0.931104	108		101	
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				
44.	Emergency	9,476,805	189,686,362	0.049960	95,604		4,776	
45.	Observation							
46.	**Ancillary Total**						**14,205**	

* 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:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Psych	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				
48.	Psych	2,823,896	13,019	216.91	310		67,242	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,153,212	9,876	521.79				
52.	Coronary Care Unit	2,823,896	4,721	598.16				
53.	SICU							
54.	Neuro-ICU	1,116,795	6,420	173.96				
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)**						**67,242**	
68.	**Ancillary Total (from line 46)**						**14,205**	
69.	**Total (Lines 67-68)**						**81,447**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	310		310
Newborn Days			
Total Inpatient Revenue	675,299		675,299
Ancillary Revenue	349,890		349,890
Routine Revenue	325,409		325,409
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