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:** 01/01/2015	**To:** 12/31/2015	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
XXXX	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

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	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 01/01/2015 and ending 12/31/2015 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 Hospital	From: 01/01/2015 To: 12/31/2015

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	1,061	387,535		254,797	65.75%		52,728	5.62
2.	Psych	96	35,136		21,735	61.86%		2,258	9.63
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	44	15,908		11,041	69.41%			
6.	Coronary Care Unit	15	5,475		4,521	82.58%			
7.	SICU	36	13,140		11,202	85.25%			
8.	Neuro-ICU	20	7,300		6,451	88.37%			
9.	Cardio-Thoracic ICU	30	10,950		8,187	74.77%			
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		6,506	74.27%			
22.	**Total**	**1,326**	**484,204**		**324,440**	**67.00%**		**54,986**	**5.78**
23.	Observation Bed Days				6,500				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,067			1,460	6.38
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				113				
6.	Coronary Care Unit				92				
7.	SICU				585				
8.	Neuro-ICU				245				
9.	Cardio-Thoracic ICU				219				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				163				
22.	**Total**				**9,484**	**2.92%**		**1,460**	**6.38**

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 Hospital	From: 01/01/2015 To: 12/31/2015

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	119,158,522	420,948,240	0.283072	7,441,183		2,106,391	
2.	Recovery Room	24,729,414	92,437,629	0.267525	879,659		235,331	
3.	Delivery and Labor Room	12,686,777	15,982,236	0.793805	394,419		313,092	
4.	Anesthesiology	13,870,981	190,515,567	0.072808	2,899,845		211,132	
5.	Radiology - Diagnostic	50,382,234	282,342,654	0.178444	3,343,123		596,560	
6.	Radiology - Therapeutic	43,322,935	277,789,610	0.155956	520,038		81,103	
7.	Nuclear Medicine	6,305,323	18,120,024	0.347975	74,158		25,805	
8.	Laboratory	77,358,964	639,002,706	0.121062	10,596,263		1,282,805	
9.	Blood							
10.	Blood - Administration	49,536,546	212,351,497	0.233276	3,982,881		929,111	
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,965,932	59,863,487	0.333524	1,387,469		462,754	
13.	Physical Therapy	8,641,956	22,461,155	0.384751	370,929		142,715	
14.	Occupational Therapy	3,078,682	7,031,119	0.437865	166,200		72,773	
15.	Speech Pathology	1,141,254	3,244,472	0.351753	95,307		33,525	
16.	EKG	9,931,795	143,716,478	0.069107	1,597,248		110,381	
17.	EEG	1,767,171	12,826,060	0.137780	193,472		26,657	
18.	Med. / Surg. Supplies	94,159,211	211,256,393	0.445711	3,742,993		1,668,293	
19.	Drugs Charged to Patients	172,660,794	429,944,876	0.401588	8,993,057		3,611,504	
20.	Renal Dialysis	6,000,530	24,941,247	0.240587	462,642		111,306	
21.	Ambulance							
22.	Ultrasound	5,490,376	49,028,143	0.111984	388,251		43,478	
23.	CT Scan	10,208,094	233,320,172	0.043751	2,716,819		118,864	
24.	MRI	15,334,306	170,281,761	0.090053	1,298,283		116,914	
25.	Cardiac Cath	14,532,682	70,643,195	0.205719	458,701		94,364	
26.	HLA Lab	5,666,650	36,101,220	0.156966	95,546		14,997	
27.	Endoscopy	11,736,089	48,440,429	0.242279	545,702		132,212	
28.	OB/GYN In Vitro	3,428,515	5,171,274	0.662992				
29.	Electroshock Therapy	703,597	2,385,217	0.294982				
30.	Corneal Tissue Acquis.	803,466	1,602,730	0.501311				
31.	Outpatient Psych	2,161,447	2,491,432	0.867552				
32.	Kidney Acquisition	14,458,157	15,636,515	0.924641				
33.	Heart Acquisition	2,759,851	1,579,482	1.747314				
34.	Liver Acquisition	5,967,631	6,992,246	0.853464	363,600		310,320	
35.	Lung Acquisition	5,387,457	5,815,349	0.926420				
36.	Pancreas Acquisition	646,006	598,668	1.079072				
37.	Bone Marrow	6,123,043	4,535,735	1.349956	93,732		126,534	
38.	Implantable Devices	137,048,647	270,964,976	0.505780	2,396,205		1,211,953	
39.	Hyperbatic Ox.Therapy	457,750	2,219,610	0.206230				
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	30,204,938	62,801,699	0.480957	52,501		25,251	
44.	Emergency	38,774,214	203,471,510	0.190563	2,106,163		401,357	
45.	Observation	6,696,885	4,493,086	1.490487	2,125		3,167	
46.	**Total**				**57,658,514**		**14,620,649**	

* 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 Hospital	From: 01/01/2015 To: 12/31/2015

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)	269,212,475	18,699,027		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	261,297	21,735		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,030.29	860.32		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,067			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,311,349			
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)	8,311,349			

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	22,097,896	11,041	2,001.44	113	226,163
9.	Coronary Care Unit	7,726,239	4,521	1,708.97	92	157,225
10.	SICU	22,160,378	11,202	1,978.25	585	1,157,276
11.	Neuro-ICU	10,851,136	6,451	1,682.09	245	412,112
12.	Cardio-Thoracic ICU	18,173,665	8,187	2,219.82	219	486,141
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,768,221	6,506	425.49	163	69,355
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					14,620,649
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**25,440,270**

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 Hospital	From: 01/01/2015 To: 12/31/2015

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 Hospital	From: 01/01/2015 To: 12/31/2015

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2015 To: 12/31/2015

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 Hospital	From: 01/01/2015 To: 12/31/2015

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)	25,440,270	
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)	2,486,816	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**27,927,086**	
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)	57,658,514	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	11,205,602	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	332,548	
	F. Coronary Care Unit	281,249	
	G. SICU	1,803,854	
	H. Neuro-ICU	702,485	
	I. Cardio-Thoracic ICU	684,800	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	129,985	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	72,799,037	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		44,871,951
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 Hospital	From: 01/01/2015 To: 12/31/2015

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)	27,927,086	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	27,927,086	
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)**	**27,927,086**	

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 Hospital	From: 01/01/2015 To: 12/31/2015

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)	44,871,951
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 Hospital	**From: 01/01/2015 To: 12/31/2015**

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: 01/01/2015 To: 12/31/2015

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	24,923,726	420,948,240	0.059209	7,441,183		440,585	
2.	Recovery Room	166,461	92,437,629	0.001801	879,659		1,584	
3.	Delivery and Labor Room	1,059,296	15,982,236	0.066280	394,419		26,142	
4.	Anesthesiology	12,060,844	190,515,567	0.063306	2,899,845		183,578	
5.	Radiology - Diagnostic	9,579,064	282,342,654	0.033927	3,343,123		113,422	
6.	Radiology - Therapeutic	2,073,194	277,789,610	0.007463	520,038		3,881	
7.	Nuclear Medicine	2,088,327	18,120,024	0.115250	74,158		8,547	
8.	Laboratory	9,367,205	639,002,706	0.014659	10,596,263		155,331	
9.	Blood							
10.	Blood - Administration	2,496,912	212,351,497	0.011758	3,982,881		46,831	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,013,898	59,863,487	0.016937	1,387,469		23,500	
13.	Physical Therapy	1,649,475	22,461,155	0.073437	370,929		27,240	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,422,483	143,716,478	0.009898	1,597,248		15,810	
17.	EEG	4,615,505	12,826,060	0.359854	193,472		69,622	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	211,859	24,941,247	0.008494	462,642		3,930	
21.	Ambulance							
22.	Ultrasound	1,301,421	49,028,143	0.026544	388,251		10,306	
23.	CT Scan	847,437	233,320,172	0.003632	2,716,819		9,867	
24.	MRI	3,359,482	170,281,761	0.019729	1,298,283		25,614	
25.	Cardiac Cath	2,209,389	70,643,195	0.031275	458,701		14,346	
26.	HLA Lab	30,266	36,101,220	0.000838	95,546		80	
27.	Endoscopy	2,058,061	48,440,429	0.042486	545,702		23,185	
28.	OB/GYN In Vitro	181,594	5,171,274	0.035116				
29.	Electroshock Therapy	211,859	2,385,217	0.088822				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,890,365	2,491,432	1.160122				
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	11,516,063	62,801,699	0.183372	52,501		9,627	
44.	Emergency	8,671,096	203,471,510	0.042616	2,106,163		89,756	
45.	Observation							
46.	**Ancillary Total**						**1,302,784**	

* 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 Hospital	From: 01/01/2015 To: 12/31/2015

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	33,897,479	261,297	129.73	8,067		1,046,532	
48.	Psych	2,633,108	21,735	121.15				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,751,700	11,041	430.37	113		48,632	
52.	Coronary Care Unit	2,587,709	4,521	572.38	92		52,659	
53.	SICU							
54.	Neuro-ICU	953,367	6,451	147.79	245		36,209	
55.	Cardio-Thoracic ICU							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**1,184,032**	
68.	**Ancillary Total (from line 46)**						**1,302,784**	
69.	**Total (Lines 67-68)**						**2,486,816**	

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 Hospital	From: 01/01/2015 To: 12/31/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,321		9,321
Newborn Days	163		163
Total Inpatient Revenue	72,799,037		72,799,037
Ancillary Revenue	57,658,514		57,658,514
Routine Revenue	15,140,523		15,140,523
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