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:** 01/01/2018	**To:** 12/31/2018	

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		
	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 01/01/2018 and ending 12/31/2018 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 12/31/2018

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	1,106	406,978		250,589	61.57%		49,494	5.99
2.	Psych	96	35,040		19,978	57.01%		2,471	8.08
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	65	20,572		15,142	73.60%			
6.	Coronary Care Unit	15	5,475		4,377	79.95%			
7.	SICU	36	13,140		10,636	80.94%			
8.	Neuro-ICU	20	7,300		6,692	91.67%			
9.	Cardio-Thoracic ICU	30	10,950		8,902	81.30%			
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		6,072	48.93%			
22.	**Total**	**1,402**	**511,865**		**322,388**	**62.98%**		**51,965**	**6.09**
23.	Observation Bed Days				7,122				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,226			736	6.97
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				240				
6.	Coronary Care Unit				49				
7.	SICU				315				
8.	Neuro-ICU				139				
9.	Cardio-Thoracic ICU				161				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				93				
22.	**Total**				**5,223**	**1.62%**		**736**	**6.97**

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: 01/01/2018 To: 12/31/2018

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	139,214,184	526,549,305	0.264390	4,284,992		1,132,909	
2.	Recovery Room	36,786,107	104,995,243	0.350360	385,947		135,220	
3.	Delivery and Labor Room	19,305,392	17,024,187	1.133998	292,727		331,952	
4.	Anesthesiology	15,975,249	191,504,808	0.083420	1,517,815		126,616	
5.	Radiology - Diagnostic	55,516,709	359,700,995	0.154341	1,986,214		306,554	
6.	Radiology - Therapeutic	60,393,063	398,926,387	0.151389	152,461		23,081	
7.	Nuclear Medicine	6,786,421	15,525,691	0.437109	31,345		13,701	
8.	Laboratory	94,635,593	697,661,701	0.135647	5,650,946		766,534	
9.	Blood							
10.	Blood - Administration	51,543,414	252,329,833	0.204270	3,276,101		669,209	
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,331,775	64,451,283	0.346491	1,096,428		379,902	
13.	Physical Therapy	8,257,892	16,472,281	0.501320	212,802		106,682	
14.	Occupational Therapy	3,702,841	9,391,401	0.394280	131,906		52,008	
15.	Speech Pathology	1,437,613	4,343,226	0.331001	84,341		27,917	
16.	EKG	10,764,103	150,651,398	0.071450	1,210,722		86,506	
17.	EEG	3,116,812	13,420,452	0.232243	161,304		37,462	
18.	Med. / Surg. Supplies	107,966,050	227,586,855	0.474395	1,828,976		867,657	
19.	Drugs Charged to Patients	225,236,361	543,200,294	0.414647	5,151,982		2,136,254	
20.	Renal Dialysis	6,954,887	19,470,913	0.357194	302,940		108,208	
21.	Ambulance							
22.	Ultrasound	7,089,624	54,358,579	0.130423	286,034		37,305	
23.	CT Scan	12,496,174	320,511,495	0.038988	2,162,198		84,300	
24.	MRI	16,716,834	167,691,432	0.099688	674,016		67,191	
25.	Cardiac Cath	18,813,131	124,743,136	0.150815	486,573		73,383	
26.	HLA Lab	7,312,575	33,451,923	0.218600	80,018		17,492	
27.	Endoscopy	14,015,760	50,659,038	0.276668	266,010		73,596	
28.	OB/GYN In Vitro	4,530,153	8,607,200	0.526321				
29.	Electroshock Therapy	790,431	2,780,233	0.284304				
30.	Corneal Tissue Acquis.	632,969	1,651,043	0.383375				
31.	Outpatient Psych	509,467	581,558	0.876038				
32.	Kidney Acquisition	16,057,885	15,535,930	1.033597				
33.	Heart Acquisition	3,253,029	1,682,484	1.933468				
34.	Liver Acquisition	9,035,990	8,871,350	1.018559	232,200		236,509	
35.	Lung Acquisition	8,490,432	7,389,325	1.149013				
36.	Pancreas Acquisition	651,756	607,586	1.072698				
37.	Bone Marrow	16,591,094	27,346,345	0.606702				
38.	Implantable Devices	145,613,159	325,561,413	0.447268	1,632,314		730,082	
39.	Hyperbatic Ox.Therapy	398,123	2,631,969	0.151264				
40.	Allogenic Stem Cell Aq	6,752,728	4,164,192	1.621618				
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	32,783,068	73,670,747	0.444994	18,498		8,231	
44.	Emergency	46,646,840	322,079,960	0.144830	1,898,623		274,978	
45.	Observation	9,265,366	7,863,642	1.178254				
46.	**Total**				**35,496,433**		**8,911,439**	

* 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: 01/01/2018 To: 12/31/2018

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)	335,268,063	25,141,657		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	257,711	19,978		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,300.95	1,258.47		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,226			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,497,815			
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)	5,497,815			

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	37,439,441	15,142	2,472.56	240	593,414
9.	Coronary Care Unit	9,409,304	4,377	2,149.72	49	105,336
10.	SICU	26,148,172	10,636	2,458.46	315	774,415
11.	Neuro-ICU	15,827,801	6,692	2,365.18	139	328,760
12.	Cardio-Thoracic ICU	22,808,827	8,902	2,562.21	161	412,516
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,112,927	6,072	842.05	93	78,311
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,911,439
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**16,702,006**

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: 01/01/2018 To: 12/31/2018

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: 01/01/2018 To: 12/31/2018

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0032	19014
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 12/31/2018

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: 01/01/2018 To: 12/31/2018

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)	16,702,006	
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)	1,613,602	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**18,315,608**	
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)	35,496,433	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,983,223	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,031,538	
	F. Coronary Care Unit	230,159	
	G. SICU	1,395,719	
	H. Neuro-ICU	680,436	
	I. Cardio-Thoracic ICU	764,786	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	114,576	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	48,696,870	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		30,381,262
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: 01/01/2018 To: 12/31/2018

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)	18,315,608	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	18,315,608	
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)**	**18,315,608**	

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: 01/01/2018 To: 12/31/2018

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)	30,381,262
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: 01/01/2018 To: 12/31/2018**

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: 01/01/2018 To: 12/31/2018

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	29,194,320	526,549,305	0.055445	4,284,992		237,581	
2.	Recovery Room	402,912	104,995,243	0.003837	385,947		1,481	
3.	Delivery and Labor Room	2,048,135	17,024,187	0.120307	292,727		35,217	
4.	Anesthesiology	7,252,413	191,504,808	0.037871	1,517,815		57,481	
5.	Radiology - Diagnostic	12,624,571	359,700,995	0.035097	1,986,214		69,710	
6.	Radiology - Therapeutic	2,417,471	398,926,387	0.006060	152,461		924	
7.	Nuclear Medicine	2,853,959	15,525,691	0.183822	31,345		5,762	
8.	Laboratory	10,475,708	697,661,701	0.015015	5,650,946		84,849	
9.	Blood							
10.	Blood - Administration	1,494,131	252,329,833	0.005921	3,276,101		19,398	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,813,103	64,451,283	0.028131	1,096,428		30,844	
13.	Physical Therapy	1,813,103	16,472,281	0.110070	212,802		23,423	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,359,827	150,651,398	0.009026	1,210,722		10,928	
17.	EEG	4,230,574	13,420,452	0.315233	161,304		50,848	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	705,096	19,470,913	0.036213	302,940		10,970	
21.	Ambulance							
22.	Ultrasound	1,997,771	54,358,579	0.036752	286,034		10,512	
23.	CT Scan	923,340	320,511,495	0.002881	2,162,198		6,229	
24.	MRI	436,488	167,691,432	0.002603	674,016		1,754	
25.	Cardiac Cath	2,165,651	124,743,136	0.017361	486,573		8,447	
26.	HLA Lab							
27.	Endoscopy	2,417,471	50,659,038	0.047720	266,010		12,694	
28.	OB/GYN In Vitro	201,456	8,607,200	0.023406				
29.	Electroshock Therapy	218,244	2,780,233	0.078498				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	2,602,139	581,558	4.474427				
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	14,286,582	73,670,747	0.193925	18,498		3,587	
44.	Emergency	9,871,340	322,079,960	0.030649	1,898,623		58,191	
45.	Observation							
46.	**Ancillary Total**						**740,830**	

* 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: 01/01/2018 To: 12/31/2018

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	35,976,667	257,711	139.60	4,226		589,950	
48.	Psych	2,887,535	19,978	144.54				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,036,398	15,142	332.61	240		79,826	
52.	Coronary Care Unit	2,367,107	4,377	540.81	49		26,500	
53.	SICU	3,726,934	10,636	350.41	315		110,379	
54.	Neuro-ICU	990,492	6,692	148.01	139		20,573	
55.	Cardio-Thoracic ICU	2,518,199	8,902	282.88	161		45,544	
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)**						**872,772**	
68.	**Ancillary Total (from line 46)**						**740,830**	
69.	**Total (Lines 67-68)**						**1,613,602**	

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: 01/01/2018 To: 12/31/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,191	(61)	5,130
Newborn Days	93		93
Total Inpatient Revenue	48,696,870		48,696,870
Ancillary Revenue	35,496,433		35,496,433
Routine Revenue	13,200,437		13,200,437
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