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:** 01/01/2023	**To:** 12/31/2023	

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 01/01/2023 and ending 12/31/2023 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: 01/01/2023 To: 12/31/2023

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	938	345,713		296,303	85.71%		48,570	7.34
2.	Psych	80	29,200		19,734	67.58%		2,670	7.39
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	67	23,702		21,555	90.94%			
6.	Coronary Care Unit	30	8,985		5,446	60.61%			
7.	SICU	36	13,140		11,788	89.71%			
8.	Neuro-ICU	29	9,619		9,560	99.39%			
9.	Cardio-Thoracic ICU	36	13,500		11,709	86.73%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	34	12,410		5,385	43.39%			
22.	**Total**	**1,250**	**456,269**		**381,480**	**83.61%**		**51,240**	**7.34**
23.	Observation Bed Days				6,868				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,493			376	8.15
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				181				
6.	Coronary Care Unit				41				
7.	SICU				136				
8.	Neuro-ICU				39				
9.	Cardio-Thoracic ICU				175				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				126				
22.	**Total**				**3,191**	**0.84%**		**376**	**8.15**

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: 01/01/2023 To: 12/31/2023

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	193,861,272	971,885,106	0.199469	4,640,221		925,580	
2.	Recovery Room	45,716,157	163,244,129	0.280048	322,555		90,331	
3.	Delivery and Labor Room	25,705,071	24,413,284	1.052913	95,265		100,306	
4.	Anesthesiology	18,508,364	297,764,289	0.062158	1,147,655		71,336	
5.	Radiology - Diagnostic	70,841,875	453,090,482	0.156353	1,428,759		223,391	
6.	Radiology - Therapeutic	77,703,191	515,670,341	0.150684	412,497		62,157	
7.	Nuclear Medicine	6,009,733	24,270,976	0.247610	11,470		2,840	
8.	Laboratory	129,224,558	819,122,842	0.157760	3,893,904		614,302	
9.	Blood							
10.	Blood - Administration	52,504,666	355,717,629	0.147602	2,568,231		379,076	
11.	Intravenous Therapy							
12.	Respiratory Therapy	30,598,546	146,501,740	0.208861	1,104,009		230,584	
13.	Physical Therapy	10,977,539	22,539,065	0.487045	156,481		76,213	
14.	Occupational Therapy	5,903,265	14,823,041	0.398249	103,666		41,285	
15.	Speech Pathology	2,313,827	5,672,447	0.407906	61,975		25,280	
16.	EKG	8,806,040	173,193,669	0.050845	751,699		38,220	
17.	EEG	4,244,348	22,951,529	0.184927	95,087		17,584	
18.	Med. / Surg. Supplies	130,786,769	296,065,277	0.441750	1,321,871		583,937	
19.	Drugs Charged to Patients	261,297,982	654,532,690	0.399213	2,528,733		1,009,503	
20.	Renal Dialysis	11,459,362	38,620,499	0.296717	279,985		83,076	
21.	Ambulance							
22.	Ultrasound	8,421,144	55,945,243	0.150525	180,717		27,202	
23.	CT Scan	14,706,858	402,648,970	0.036525	1,339,061		48,909	
24.	MRI	23,829,388	248,799,787	0.095777	402,262		38,527	
25.	Cardiac Cath	15,598,527	152,706,460	0.102147	576,988		58,938	
26.	HLA Lab	8,766,765	35,619,769	0.246121	41,056		10,105	
27.	Endoscopy	14,063,854	57,462,572	0.244748	104,647		25,612	
28.	OB/GYN In Vitro	5,903,295	12,259,921	0.481512				
29.	Electroshock Therapy	953,094	3,984,911	0.239176				
30.	Corneal Tissue Acquis.	737,780	2,014,600	0.366217				
31.	Outpatient Psych	1,165,636	709,416	1.643092				
32.	Kidney Acquisition	28,355,167	31,864,000	0.889881				
33.	Heart Acquisition	6,537,974	6,047,500	1.081104				
34.	Liver Acquisition	15,530,155	12,442,000	1.248204	95,000		118,579	
35.	Lung Acquisition	8,921,501	8,541,000	1.044550				
36.	Pancreas Acquisition	849,367	923,000	0.920224				
37.	Car-T Acquisition	37,091,430	66,323,998	0.559246				
38.	Implantable Devices	167,484,125	372,956,410	0.449072	1,974,102		886,514	
39.	Hyperbatic Ox.Therapy	452,283	3,286,620	0.137613				
40.	Allogenic Stem Cell Aq	7,710,593	12,065,739	0.639049				
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	43,808,836	124,699,192	0.351316	7,615		2,675	
44.	Emergency	54,573,723	405,324,816	0.134642	1,571,632		211,608	
45.	Observation	11,585,286	18,200,804	0.636526	35,030		22,298	
46.	**Total**				**27,252,173**		**6,025,968**	

* 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: 01/01/2023 To: 12/31/2023

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)	511,405,064	33,288,367		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	303,171	19,734		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,686.85	1,686.85		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,493			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,205,317			
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)	4,205,317			

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	64,811,052	21,555	3,006.78	181	544,227
9.	Coronary Care Unit	16,735,610	5,446	3,073.01	41	125,993
10.	SICU	35,243,705	11,788	2,989.80	136	406,613
11.	Neuro-ICU	27,204,090	9,560	2,845.62	39	110,979
12.	Cardio-Thoracic ICU	39,283,595	11,709	3,354.99	175	587,123
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,241,766	5,385	973.40	126	122,648
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					6,025,968
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**12,128,868**

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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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.	Car-T Acquisition							
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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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)	12,128,868	
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)	957,755	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**13,086,623**	
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)	27,252,173	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	9,151,659	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,384,773	
	F. Coronary Care Unit	313,650	
	G. SICU	1,041,138	
	H. Neuro-ICU	297,400	
	I. Cardio-Thoracic ICU	1,338,750	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	365,200	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	41,144,743	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		28,058,120
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: 01/01/2023 To: 12/31/2023

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)	13,086,623	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	13,086,623	
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)**	**13,086,623**	

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: 01/01/2023 To: 12/31/2023

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)	28,058,120
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		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 **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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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	36,971,828	971,885,106	0.038041	4,640,221		176,519	
2.	Recovery Room	237,888	163,244,129	0.001457	322,555		470	
3.	Delivery and Labor Room	3,627,799	24,413,284	0.148599	95,265		14,156	
4.	Anesthesiology	9,852,546	297,764,289	0.033088	1,147,655		37,974	
5.	Radiology - Diagnostic	13,678,585	453,090,482	0.030190	1,428,759		43,134	
6.	Radiology - Therapeutic	2,636,597	515,670,341	0.005113	412,497		2,109	
7.	Nuclear Medicine	2,795,189	24,270,976	0.115166	11,470		1,321	
8.	Laboratory	12,687,383	819,122,842	0.015489	3,893,904		60,313	
9.	Blood							
10.	Blood - Administration	1,466,979	355,717,629	0.004124	2,568,231		10,591	
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,854,661	146,501,740	0.019486	1,104,009		21,513	
13.	Physical Therapy	1,387,683	22,539,065	0.061568	156,481		9,634	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,764,339	173,193,669	0.010187	751,699		7,658	
17.	EEG	3,786,391	22,951,529	0.164973	95,087		15,687	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	911,906	38,620,499	0.023612	279,985		6,611	
21.	Ambulance							
22.	Ultrasound	2,656,421	55,945,243	0.047483	180,717		8,581	
23.	CT Scan	1,090,322	402,648,970	0.002708	1,339,061		3,626	
24.	MRI	674,017	248,799,787	0.002709	402,262		1,090	
25.	Cardiac Cath	3,033,078	152,706,460	0.019862	576,988		11,460	
26.	HLA Lab							
27.	Endoscopy	2,378,884	57,462,572	0.041399	104,647		4,332	
28.	OB/GYN In Vitro	257,712	12,259,921	0.021021				
29.	Electroshock Therapy	237,888	3,984,911	0.059697				
30.	Corneal Tissue Acquis.							
31.	Outpatient Psych	3,429,558	709,416	4.834340				
32.	Kidney Acquisition							
33.	Heart Acquisition							
34.	Liver Acquisition							
35.	Lung Acquisition							
36.	Pancreas Acquisition							
37.	Car-T Acquisition							
38.	Implantable Devices							
39.	Hyperbatic Ox.Therapy							
40.	Allogenic Stem Cell Aq							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	19,804,212	124,699,192	0.158816	7,615		1,209	
44.	Emergency	12,033,190	405,324,816	0.029688	1,571,632		46,659	
45.	Observation							
46.	**Ancillary Total**						**484,647**	

* 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: 01/01/2023 To: 12/31/2023

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	36,703,873	303,171	121.07	2,493		301,828	
48.	Psych	2,389,128	19,734	121.07				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,927,387	21,555	274.99	181		49,773	
52.	Coronary Care Unit	2,894,309	5,446	531.46	41		21,790	
53.	SICU	3,905,335	11,788	331.30	136		45,057	
54.	Neuro-ICU	2,359,060	9,560	246.76	39		9,624	
55.	Cardio-Thoracic ICU	3,013,254	11,709	257.35	175		45,036	
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)**						**473,108**	
68.	**Ancillary Total (from line 46)**						**484,647**	
69.	**Total (Lines 67-68)**						**957,755**	

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: 01/01/2023 To: 12/31/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,250	(185)	3,065
Newborn Days	80	46	126
Total Inpatient Revenue	41,663,725	(518,982)	41,144,743
Ancillary Revenue	27,358,655	(106,482)	27,252,173
Routine Revenue	14,305,070	(412,500)	13,892,570
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Excluded Labor & Delivery days from both Part I and Part II
BHF Page 2 - Reclassified 80 beds and 29,200 Bed days available and 19,734 IP days from Part I-Hospital A&P to Psych per email from the provider. The hospital is a nonDPU facility.
BHF Page 2 - Reclassified 46 nursery days in Part II-Program from A&P to Nursery
BHF Page 2 - Reclassified 124 Psych days (per IPCR) from Part II-Program A&P days to the Psych cost report
BHF Page 2 - Reclassified 2670 Number of Discharges from the Acute to Psych; Used the 7.39 ave length of stay to arrive at the 2670 for Psych and subtracted the Psych amount from the total to arrive at the Acute amount
BHF Page 3 - Reclassified the Blood Costs/Charges to Blood Admin as covered by IL Medicaid
BHF Page 3 - Pulled the IP Psych charges from the Acute report (per the IPCR) to the Psych cost report
BHF Page 4 - Adjusted the Routine Costs on Line 1a to agree with W/S D-1, Line 27 of the Medicare report
BHF Page 4 - Allocated the A&P Routine costs between A&P and Psych; see attached spreadsheet
BHF Page 7 - Reclassified $412,500 of A&P charges to the Psych cost report; amount comes from the IPCR
BHF Supplemental 2b - Allocated the A&P GME Expenses between A&P and Psych; see attached spreadsheet