

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: St. John's Mercy Medical Center		Medicare Provider Number: 26-0020
Street: 615 South New Ballas Road		Medicaid Provider Number: 19029
City: St. Louis	State: MO	Zip: 63141
Period Covered by Statement:	From: 07/01/2009	To: 06/30/2010

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☒ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☒ 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	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I	☐ Medicaid Sub III	☐ 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)) St. John's Mercy Medical Cen 19029 for the cost report beginning 07/01/2009 and ending 06/30/2010 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Name (Typewritten)

Title

Date

Firm

Telephone Number

Name (Typewritten)

Title

Date

Telephone Number

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

BHF Page 2

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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	552	201,480		103,560	51.40%		34,414	5.46
2.	Psych	48	17,520		15,816	90.27%		2,336	6.77
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	145	52,925		52,605	99.40%			
6.	Coronary Care Unit	17	6,205		6,091	98.16%			
7.	NICU	97	35,405		25,487	71.99%			
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	88	32,120		19,058	59.33%			
22.	Total	947	345,655		222,617	64.40%		36,750	5.54
23.	Observation Bed Days				7,766				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				407			113	5.31
2.	Psych								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				147				
6.	Coronary Care Unit				6				
7.	NICU				40				
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				30				
22.	Total				630	0.28%		113	5.31

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

BHF Page 3

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	41,926,365	102,031,061	0.410918	192,529		79,114	
2.	Recovery Room	4,000,517	30,692,868	0.130340	41,390		5,395	
3.	Delivery and Labor Room	18,889,485	47,568,079	0.397104	59,794		23,744	
4.	Anesthesiology	5,471,702	33,623,315	0.162735	57,806		9,407	
5.	Radiology - Diagnostic	20,524,633	115,375,518	0.177894	69,948		12,443	
6.	Radiology - Therapeutic	12,655,421	64,455,497	0.196344	3,428		673	
7.	Nuclear Medicine	6,203,947	40,617,235	0.152742	11,272		1,722	
8.	Laboratory	30,471,898	288,305,269	0.105693	435,800		46,061	
9.	Blood							
10.	Blood - Administration	8,879,635	23,932,884	0.371022	165,202		61,294	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,143,776	55,178,935	0.256326	299,776		76,840	
13.	Physical Therapy	13,811,241	29,854,469	0.462619	92,956		43,003	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	12,180,462	108,570,701	0.112189	136,916		15,360	
17.	EEG							
18.	Med. / Surg. Supplies	92,250,719	237,824,577	0.387894	1,237,252		479,923	
19.	Drugs Charged to Patients	58,932,366	220,121,683	0.267726	648,475		173,614	
20.	Renal Dialysis	2,742,754	8,579,243	0.319697	2,511		803	
21.	Ambulance	44,096	24,400	1.807213				
22.	Ultrasound	4,320,607	29,213,003	0.147900	5,108		755	
23.	CT Scan	5,785,944	122,648,433	0.047175	44,967		2,121	
24.	MRI	3,124,429	40,110,290	0.077896	19,102		1,488	
25.	Oncology							
26.								
27.	ASC	6,318,178	15,276,442	0.413590	3,942		1,630	
28.	Cardiac Cath Lab	8,200,537	57,092,405	0.143636	28,173		4,047	
29.	GI Service	5,536,768	44,923,408	0.123249	9,563		1,179	
30.	Electroconvulsive Therapy	292,842	3,039,986	0.096330				
31.	OP Psych	1,364,590	1,444,731	0.944529				
32.	Urgent Care Ctr - St Peters							
33.	Hyperbaric/OP Wound Ctr	1,372,142	2,053,557	0.668178				
34.								
35.	Ambulatory Care Unit	2,073,375	18,668,198	0.111065				
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	15,077,118	18,688,498	0.806759				
44.	Emergency	22,577,389	97,366,752	0.231880				
45.	Observation	6,033,483	20,418,747	0.295487				
46.	Total				3,565,910		1,040,616	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

BHF Page 4

PRELIMINARY

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	85,765,259	12,658,492		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	111,326	15,816		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	770.40	800.36		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	407			
3.	Program general inpatient routine cost (Line 1c X Line 2)	313,553			
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)	313,553			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	51,100,679	52,605	971.40	147	142,796
9.	Coronary Care Unit	12,954,135	6,091	2,126.77	6	12,761
10.	NICU	24,797,643	25,487	972.95	40	38,918
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	9,341,262	19,058	490.15	30	14,705
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,040,616
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,563,349

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

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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	1,952,250	102,031,061	0.019134	192,529		3,684	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	608,294	115,375,518	0.005272	69,948		369	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	10,654	288,305,269	0.000037	435,800		16	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	158,100	55,178,935	0.002865	299,776		859	
13.	Physical Therapy	1,205,371	29,854,469	0.040375	92,956		3,753	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,396,951	108,570,701	0.012867	136,916		1,762	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound	1,914,498	29,213,003	0.065536	5,108		335	
23.	CT Scan	3,967	122,648,433	0.000032	44,967		1	
24.	MRI							
25.	Oncology							
26.								
27.	ASC							
28.	Cardiac Cath Lab							
29.	GI Service							
30.	Electroconvulsive Therapy							
31.	OP Psych							
32.	Urgent Care Ctr - St Peters							
33.	Hyperbaric/OP Wound Ctr	206,046	2,053,557	0.100336				
34.								
35.	Ambulatory Care Unit							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	2,369,654	18,688,498	0.126797				
44.	Emergency	10,472,835	97,366,752	0.107561				
45.	Observation							
46.	Ancillary Total						10,779	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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	15,728,057	111,326	141.28	407		57,501	
48.	Psych	1,160,785	15,816	73.39				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit	2,371,295	6,091	389.31	6		2,336	
53.	NICU	320,417	25,487	12.57	40		503	
54.	Other							
55.	Other							
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)						60,340	
68.	Ancillary Total (from line 46)						10,779	
69.	Total (Lines 67-68)						71,119	

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

BHF Page 7

PRELIMINARY

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		1,563,349	
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)		71,119	
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)		42,837	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,677,305	
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	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		3,565,910	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		147,789	
B. Psych			
C. Sub II			
D. Sub III			
E. Intensive Care Unit		1,073,500	
F. Coronary Care Unit		15,696	
G. NICU		97,007	
H. Other			
I. Other			
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)		4,899,902	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			3,222,597
14. Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)			
15. Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)			

Hospital Statement of Cost / Computation of Allowable Cost

BHF Page 8

PRELIMINARY

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	1,677,305	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,677,305	
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	1,677,305	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	3,222,597
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, 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 Sub II	Sub III Sub III
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 Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Sub II	Sub III Sub III
(A)	General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B)	Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C)	Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
(A)	Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B)	Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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 1)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	2,786,060	102,031,061	0.027306	192,529		5,257	
2.	Recovery Room							
3.	Delivery and Labor Room	763,393	47,568,079	0.016048	59,794		960	
4.	Anesthesiology	222,192	33,623,315	0.006608	57,806		382	
5.	Radiology - Diagnostic	96,016	115,375,518	0.000832	69,948		58	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	124,812	55,178,935	0.002262	299,776		678	
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	1,370,951	8,579,243	0.159799	2,511		401	
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan							
24.	MRI							
25.	Oncology							
26.								
27.	ASC							
28.	Cardiac Cath Lab							
29.	GI Service	112,459	44,923,408	0.002503	9,563		24	
30.	Electroconvulsive Therapy							
31.	OP Psych							
32.	Urgent Care Ctr - St Peters							
33.	Hyperbaric/OP Wound Ctr							
34.								
35.	Ambulatory Care Unit							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	219,384	18,688,498	0.011739				
44.	Emergency	331,443	97,366,752	0.003404				
45.	Observation							
46.	Ancillary Total						7,760	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	8,022,409	111,326	72.06	407		29,328	
48.	Psych	265,106	15,816	16.76				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,794,620	52,605	34.12	147		5,016	
52.	Coronary Care Unit	590,132	6,091	96.89	6		581	
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	96,417	19,058	5.06	30		152	
67.	Routine Total (lines 47-66)						35,077	
68.	Ancillary Total (from line 46)						7,760	
69.	Total (Lines 67-68)						42,837	

PRELIMINARY

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2009 To: 06/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	600		600
Newborn Days	30		30
Total Inpatient Revenue	4,899,902		4,899,902
Ancillary Revenue	3,565,910		3,565,910
Routine Revenue	1,333,992		1,333,992
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Included filed Medicaid Psych days with Adults and Pediatrics (374+33=407)

Observation Days were taken from filed S-3.

Reclassified Blood as Blood-Admin.

BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.

GME Costs were adjusted to filed W/S B, Pt 1, Col 26.

Med/Surg Supplies costs & charges include Implantable Devices.