

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: 07/01/2010	To: 06/30/2011

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 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)) St. John's Mercy Medical Cen 19029 for the cost report beginning 07/01/2010 and ending 06/30/2011 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	
Email Address	

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

BHF Page 2

Preliminary

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	486	177,390		98,286	55.41%		36,844	4.96
2.	Psych	48	17,520		15,515	88.56%		2,434	6.37
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	134	48,910		46,162	94.38%			
6.	Coronary Care Unit	17	6,205		4,868	78.45%			
7.	NICU	98	35,770		25,074	70.10%			
8.	Burn ICU	9	3,285		2,256	68.68%			
9.	Surgical ICU	17	6,205		5,921	95.42%			
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		18,943	58.98%			
22.	Total	897	327,405		217,025	66.29%		39,278	5.04
23.	Observation Bed Days				10,649				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				206			107	8.93
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				204				
6.	Coronary Care Unit								
7.	NICU				411				
8.	Burn ICU				134				
9.	Surgical ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				23				
22.	Total				978	0.45%		107	8.93

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:		Medicaid Provider Number:	
26-0020		19029	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2010	To: 06/30/2011

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	40,099,120	104,451,281	0.383903	217,750		83,595	
2.	Recovery Room	3,838,801	31,337,986	0.122497	51,891		6,356	
3.	Delivery and Labor Room	18,106,026	50,948,778	0.355377	76,611		27,226	
4.	Anesthesiology	2,861,984	38,896,899	0.073579	58,671		4,317	
5.	Radiology - Diagnostic	22,175,452	121,606,542	0.182354	87,381		15,934	
6.	Radiology - Therapeutic	13,674,816	60,006,851	0.227888	21,347		4,865	
7.	Nuclear Medicine	3,779,612	46,065,871	0.082048	7,772		638	
8.	Laboratory	30,021,816	302,825,819	0.099139	460,848		45,688	
9.	Blood							
10.	Blood - Administration	8,041,540	25,340,410	0.317341	129,621		41,134	
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,513,283	49,036,202	0.275578	132,035		36,386	
13.	Physical Therapy	14,376,027	30,996,666	0.463793	100,419		46,574	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	15,499,778	121,771,183	0.127286	66,084		8,412	
17.	EEG							
18.	Med. / Surg. Supplies	41,704,386	160,300,687	0.260163	1,220,690		317,578	
19.	Drugs Charged to Patients	78,612,114	256,494,681	0.306486	591,618		181,323	
20.	Renal Dialysis	2,192,337	9,438,608	0.232273				
21.	Ambulance	44,648	35,474	1.258612				
22.	Ultrasound	4,156,168	31,804,886	0.130677	29,008		3,791	
23.	CT Scan	3,604,115	116,745,191	0.030872	106,778		3,296	
24.	MRI	3,146,855	41,494,261	0.075838	20,770		1,575	
25.	Cardiac Rehab	1,487,651	1,265,191	1.175831	1,458		1,714	
26.	ASC	9,988,906	19,871,335	0.502679	6,797		3,417	
27.	Cardiac Cath Lab	9,061,849	54,014,862	0.167766	2,021		339	
28.	GI Service	4,661,846	46,311,426	0.100663	21,890		2,204	
29.	Electroconvulsive Ther.	429,066	3,258,821	0.131663				
30.	OP Psych	2,537,854	3,807,041	0.666621				
31.	Implant Dev. Charged	43,262,368	86,623,650	0.499429	93,151		46,522	
32.	Hyperbaric/OP Wound	1,069,361	1,605,137	0.666212				
33.	Ambulatory Care Unit	2,126,387	24,294,391	0.087526				
34.	Oncology							
35.	Urgent Care-St. Peters							
36.	Natural Fam. Planning							
37.	Pain Therapy Center							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	5,782,672	12,019,776	0.481096				
44.	Emergency	21,309,873	102,448,928	0.208005				
45.	Observation	8,184,608	26,517,638	0.308648				
46.	Total				3,504,611		882,884	

* 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: 07/01/2010 To: 06/30/2011

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)	82,229,592	12,184,499		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	108,935	15,515		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	754.85	785.34		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	206			
3.	Program general inpatient routine cost (Line 1c X Line 2)	155,499			
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)	155,499			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	48,795,411	46,162	1,057.05	204	215,638
9.	Coronary Care Unit	11,758,525	4,868	2,415.47		
10.	NICU	25,327,242	25,074	1,010.10	411	415,151
11.	Burn ICU	3,309,563	2,256	1,467.00	134	196,578
12.	Surgical ICU	4,327,166	5,921	730.82		
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	10,392,513	18,943	548.62	23	12,618
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					882,884
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,878,368

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: 07/01/2010 To: 06/30/2011

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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.	NICU						
9.	Burn ICU						
10.	Surgical 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45) (5A) (5B)		Program Expenses (Col. 4 X Cols. 5A-B) (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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	2,746,383	104,451,281	0.026293	217,750		5,725	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	583,898	121,606,542	0.004802	87,381		420	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	127,670	302,825,819	0.000422	460,848		194	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	144,066	49,036,202	0.002938	132,035		388	
13.	Physical Therapy	1,319,304	30,996,666	0.042563	100,419		4,274	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,451,632	121,771,183	0.020133	66,084		1,330	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound	1,883,303	31,804,886	0.059214	29,008		1,718	
23.	CT Scan	18,022	116,745,191	0.000154	106,778		16	
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Service							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound							
33.	Ambulatory Care Unit							
34.	Oncology							
35.	Urgent Care-St. Peters							
36.	Natural Fam. Planning							
37.	Pain Therapy Center							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	343,507	12,019,776	0.028578				
44.	Emergency	8,639,449	102,448,928	0.084329				
45.	Observation							
46.	Ancillary Total						14,065	

* 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: 07/01/2010 To: 06/30/2011

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	16,127,664	108,935	148.05	206		30,498	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	1,962,358	4,868	403.11				
53.	NICU	315,000	25,074	12.56	411		5,162	
54.	Burn ICU							
55.	Surgical 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)						35,660	
68.	Ancillary Total (from line 46)						14,065	
69.	Total (Lines 67-68)						49,725	

**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: 07/01/2010 To: 06/30/2011

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)		1,878,368	
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)		49,725	
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)		46,879	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,974,972	
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)		3,504,611	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		238,997	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		1,065,860	
F. Coronary Care Unit		325,774	
G. NICU		575,962	
H. Burn ICU		3,010	
I. Surgical ICU			
J. Other			
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		10,732	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		5,724,946	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			3,749,974
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: 07/01/2010 To: 06/30/2011

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)	1,974,972	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,974,972	
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)	1,974,972	

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: 07/01/2010 To: 06/30/2011

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)	3,749,974
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: 07/01/2010 To: 06/30/2011

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	4,584,709	104,451,281	0.043893	217,750		9,558	
2.	Recovery Room							
3.	Delivery and Labor Room	1,143,666	50,948,778	0.022447	76,611		1,720	
4.	Anesthesiology	41,058	38,896,899	0.001056	58,671		62	
5.	Radiology - Diagnostic	190,157	121,606,542	0.001564	87,381		137	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	149,843	49,036,202	0.003056	132,035		403	
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	1,443,131	9,438,608	0.152897				
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Service	127,267	46,311,426	0.002748	21,890		60	
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound							
33.	Ambulatory Care Unit							
34.	Oncology							
35.	Urgent Care-St. Peters							
36.	Natural Fam. Planning							
37.	Pain Therapy Center							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	344,216	12,019,776	0.028637				
44.	Emergency	622,690	102,448,928	0.006078				
45.	Observation							
46.	Ancillary Total						11,940	

* 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: 07/01/2010 To: 06/30/2011

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	11,562,554	108,935	106.14	206		21,865	
48.	Psych	429,805	15,515	27.70				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,923,665	46,162	63.33	204		12,919	
52.	Coronary Care Unit	1,183,359	4,868	243.09				
53.	NICU							
54.	Burn ICU							
55.	Surgical ICU							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	127,267	18,943	6.72	23		155	
67.	Routine Total (lines 47-66)						34,939	
68.	Ancillary Total (from line 46)						11,940	
69.	Total (Lines 67-68)						46,879	

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	955		955
Newborn Days	23		23
Total Inpatient Revenue	5,724,946		5,724,946
Ancillary Revenue	3,504,611		3,504,611
Routine Revenue	2,220,335		2,220,335
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Observation bed days were adjusted to agree with as filed W/S S-3

BHF page 3 - reclassified Blood as Blood Admin.

BHF page 3 costs were adjusted to filed W/S C Part I, col 1, as applicable

GME costs were adjusted to as filed W/S B Part 1, col 25

BHF page 6 - Reclassified professional component from Oncology to Adults and Peds.

BHF page 7 - Included special care charges under each applicable special care unit