

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: Mercy Hospital-St. Louis		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: 07/01/2012	To: 06/30/2013

Type of Control

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

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)) Mercy Hospital-St. Louis 19029 for the cost report beginning 07/01/2012 and ending 06/30/2013 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: 07/01/2012 To: 06/30/2013

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	622	226,999		125,933	55.48%		36,360	4.63
2.	Psych	48	17,520		15,651	89.33%		2,643	5.92
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		11,091	46.04%			
6.	Coronary Care Unit	16	5,840		4,613	78.99%			
7.	NICU	98	35,770		23,850	66.68%			
8.	Burn ICU	9	3,285		2,944	89.62%			
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	90	32,850		18,377	55.94%			
22.	Total	949	346,354		202,459	58.45%		39,003	4.72
23.	Observation Bed Days				9,020				

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program								
1. Adults and Pediatrics				360			135	9.73
2. Psych								
3. Rehab								
4. Other (Sub)								
5. Intensive Care Unit				175				
6. Coronary Care Unit				2				
7. NICU				564				
8. Burn ICU				212				
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				38				
22. Total				1,351	0.67%		135	9.73

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: 07/01/2012 To: 06/30/2013

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	47,270,029	128,371,153	0.368229	339,010		124,833	
2.	Recovery Room	3,971,870	27,934,230	0.142186	45,916		6,529	
3.	Delivery and Labor Room	22,620,216	68,403,905	0.330686	137,270		45,393	
4.	Anesthesiology	2,382,375	47,098,952	0.050582	92,771		4,693	
5.	Radiology - Diagnostic	20,990,177	126,724,413	0.165636	170,403		28,225	
6.	Radiology - Therapeutic	12,673,362	69,015,252	0.183631	66,824		12,271	
7.	Nuclear Medicine	3,795,527	41,789,291	0.090825	6,486		589	
8.	Laboratory	32,467,960	323,027,959	0.100511	794,184		79,824	
9.	Blood							
10.	Blood - Administration	8,173,643	25,427,138	0.321454	238,774		76,755	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,437,537	75,392,729	0.191498	361,169		69,163	
13.	Physical Therapy	19,464,938	40,082,660	0.485620	151,612		73,626	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	12,000,842	127,875,530	0.093848	170,280		15,980	
17.	EEG							
18.	Med. / Surg. Supplies	48,713,088	142,137,729	0.342718	2,513,040		861,264	
19.	Drugs Charged to Patients	78,678,054	256,738,749	0.306452	1,313,473		402,516	
20.	Renal Dialysis	1,204,397	5,417,093	0.222333				
21.	Ambulance	4,846	6,003	0.807263				
22.	Ultrasound	4,542,934	33,123,235	0.137152	27,510		3,773	
23.	CT Scan	2,806,823	111,854,216	0.025094	160,859		4,037	
24.	MRI	2,383,627	39,111,043	0.060945	17,907		1,091	
25.	Cardiac Rehab	1,711,981	1,809,305	0.946209				
26.	ASC	10,676,617	29,256,371	0.364933	7,755		2,830	
27.	Cardiac Cath Lab	6,279,629	44,954,088	0.139690	65,810		9,193	
28.	GI Lab	8,091,441	66,445,337	0.121776	2,502		305	
29.	Electroconvulsive Ther.	387,957	3,389,954	0.114443				
30.	OP Psych	2,360,111	3,765,275	0.626810				
31.	Implant Dev. Charged	44,675,340	96,577,385	0.462586	198,219		91,693	
32.	Hyperbaric/OP Wound	1,147,458	2,261,844	0.507311				
33.	Ambulatory Care Unit	3,142,790	24,964,437	0.125891				
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	5,148,719	16,201,091	0.317801				
44.	Emergency	25,435,567	112,240,919	0.226616				
45.	Observation	6,931,870	31,657,540	0.218964				
46.	Total				6,881,774		1,914,583	

* 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: 07/01/2012 To: 06/30/2013

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)	102,747,632	12,314,765		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	134,953	15,651		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	761.36	786.84		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	360			
3.	Program general inpatient routine cost (Line 1c X Line 2)	274,090			
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)	274,090			

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	29,072,939	11,091	2,621.31	175	458,729
9.	Coronary Care Unit	6,322,015	4,613	1,370.48	2	2,741
10.	NICU	24,561,070	23,850	1,029.81	564	580,813
11.	Burn ICU	3,919,146	2,944	1,331.23	212	282,221
12.	Surgical ICU					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	9,630,760	18,377	524.07	38	19,915
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,914,583
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,533,092

**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: 07/01/2012 To: 06/30/2013

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)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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: 07/01/2012 To: 06/30/2013

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	895,889	128,371,153	0.006979	339,010		2,366	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	462,344	126,724,413	0.003648	170,403		622	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	118,170	323,027,959	0.000366	794,184		291	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	42,423	75,392,729	0.000563	361,169		203	
13.	Physical Therapy	1,404,276	40,082,660	0.035035	151,612		5,312	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,036,356	127,875,530	0.023745	170,280		4,043	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound	3,470	33,123,235	0.000105	27,510		3	
23.	CT Scan	3,209	111,854,216	0.000029	160,859		5	
24.	MRI							
25.	Cardiac Rehab							
26.	ASC	106,425	29,256,371	0.003638	7,755		28	
27.	Cardiac Cath Lab	186	44,954,088	0.000004	65,810			
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	177,913	2,261,844	0.078658				
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	474,822	16,201,091	0.029308				
44.	Emergency	8,194,120	112,240,919	0.073005				
45.	Observation							
46.	Ancillary Total						12,873	

* 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: 07/01/2012 To: 06/30/2013

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	14,651,894	134,953	108.57	360		39,085	
48.	Psych	1,532,984	15,651	97.95				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	7,188,062	11,091	648.10	175		113,418	
52.	Coronary Care Unit							
53.	NICU	315,000	23,850	13.21	564		7,450	
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)						159,953	
68.	Ancillary Total (from line 46)						12,873	
69.	Total (Lines 67-68)						172,826	

**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: 07/01/2012 To: 06/30/2013

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)		3,533,092	
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)		172,826	
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)		78,311	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		3,784,229	
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)		6,881,774	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		859,209	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		63,487	
F. Coronary Care Unit		6,574	
G. NICU		1,524,813	
H. Burn ICU		1,126,556	
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		322	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		10,462,735	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			6,678,506
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: 07/01/2012 To: 06/30/2013

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)	3,784,229	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,784,229	
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)	3,784,229	

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: 07/01/2012 To: 06/30/2013

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)	6,678,506
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 07/01/2012 To: 06/30/2013

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:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2012 To: 06/30/2013

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	2,291,191	128,371,153	0.017848	339,010		6,051	
2.	Recovery Room							
3.	Delivery and Labor Room	968,393	68,403,905	0.014157	137,270		1,943	
4.	Anesthesiology	38,844	47,098,952	0.000825	92,771		77	
5.	Radiology - Diagnostic	25,621	126,724,413	0.000202	170,403		34	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	105,488	75,392,729	0.001399	361,169		505	
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 Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Lab	78,139	66,445,337	0.001176	2,502		3	
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	291,217	16,201,091	0.017975				
44.	Emergency	457,562	112,240,919	0.004077				
45.	Observation							
46.	Ancillary Total						8,613	

* 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: 07/01/2012 To: 06/30/2013

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	6,958,173	134,953	51.56	360		18,562	
48.	Psych	207,519	15,651	13.26				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,205,414	11,091	289.01	175		50,577	
52.	Coronary Care Unit	912,495	4,613	197.81	2		396	
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	78,589	18,377	4.28	38		163	
67.	Routine Total (lines 47-66)						69,698	
68.	Ancillary Total (from line 46)						8,613	
69.	Total (Lines 67-68)						78,311	

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,313		1,313
Newborn Days	38		38
Total Inpatient Revenue	10,463,877	(1,142)	10,462,735
Ancillary Revenue	6,882,916	(1,142)	6,881,774
Routine Revenue	3,580,961		3,580,961
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]