

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 and Medical Center		Medicare Provider Number: 14-0158	
Street: 2525 S. Michigan		Medicaid Provider Number: 3042	
City: Chicago	State: Illinois	Zip: 60616	
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 and Medical C 3042 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:	14-0158	Medicaid Provider Number:	3042
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	198	72,270		42,560	58.89%	13,094	13,094	3.90
2.	Psych	39	14,274		5,613	39.32%	1,031	1,031	5.44
3.	Rehab	16	5,978		4,408	73.74%	383	383	11.51
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,110		4,253	83.23%			
6.	Coronary Care Unit	6	2,190		1,439	65.71%			
7.	NICU	15	5,475		2,795	51.05%			
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	15	5,475		3,839	70.12%			
22.	Total	303	110,772		64,907	58.60%	14,508	14,508	4.21
23.	Observation Bed Days				4,764				

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program								
1. Adults and Pediatrics				14,165		5,840	5,840	3.02
2. Psych								
3. Rehab								
4. Other (Sub)								
5. Intensive Care Unit				1,064				
6. Coronary Care Unit				254				
7. NICU				2,145				
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				2,947				
22. Total				20,575	31.70%	5,840	5,840	3.02

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:	
14-0158		3042	
Program:		Period Covered by Statement:	
Medicaid Hospital		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)	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)		(4)	(5)	(6)	(7)
1.	Operating Room	15,687,722	27,356,102	0.573463	2,666,489		1,529,133	
2.	Recovery Room	1,351,882	3,825,817	0.353358	243,635		86,090	
3.	Delivery and Labor Room	6,171,451	18,056,989	0.341776	12,584,479		4,301,073	
4.	Anesthesiology	637,162	4,039,394	0.157737	643,963		101,577	
5.	Radiology - Diagnostic	9,264,009	36,641,443	0.252829	2,054,383		519,408	
6.	Radiology - Therapeutic	1,236,202	4,688,496	0.263667	62,201		16,400	
7.	Nuclear Medicine	1,414,151	6,698,075	0.211128	279,222		58,952	
8.	Laboratory	14,603,453	112,524,598	0.129780	15,216,240		1,974,764	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,903,946	14,555,762	0.199505	3,205,487		639,511	
13.	Physical Therapy	2,082,811	4,742,232	0.439205	313,085		137,508	
14.	Occupational Therapy	1,717,060	2,571,935	0.667614	287,809		192,145	
15.	Speech Pathology	551,526	1,273,117	0.433209	134,338		58,196	
16.	EKG							
17.	EEG	155,797	342,579	0.454777	54,758		24,903	
18.	Med. / Surg. Supplies	518	110,582	0.004684				
19.	Drugs Charged to Patients	21,373,865	53,144,907	0.402181	6,787,585		2,729,838	
20.	Renal Dialysis	1,175,676	4,242,454	0.277122	871,420		241,490	
21.	Ambulance							
22.	MRI	1,671,707	7,299,813	0.229007	466,664		106,869	
23.	GI Lab	2,028,519	8,907,015	0.227744	398,802		90,825	
24.	Cardiac Catheterization	7,623,573	50,535,202	0.150857	4,944,269		745,878	
25.	EMG	84,666	497,250	0.170268	1,972		336	
26.	Implant Supplies	9,740,193	15,939,142	0.611086	1,539,140		940,547	
27.	Cardiac Rehab							
28.	Mercy Eye Center	839,562	1,081,508	0.776288				
29.	Wound Care Center	458,712	534,920	0.857534	3,225		2,766	
30.	CT Scan	2,285,432	28,227,899	0.080964	1,982,187		160,486	
31.	Vein Clinic	47,531	167,782	0.283290				
32.	Mental Health Center	1,306,883	1,187,905	1.100158				
33.	Pre Birth Center	537,964	3,104,851	0.173266				
34.	Sleep Lab	416,607	1,786,993	0.233133				
35.	Urology	128,012	24,350	5.257166				
36.	Diabetes Center	266,868	145,654	1.832205				
37.	ADDP OP	749,044	2,845,972	0.263194				
38.	Mercy Clinic Polk St							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	5,813,330	8,022,032	0.724671				
44.	Emergency	9,964,161	47,509,847	0.209728	3,627,332		760,753	
45.	Observation	4,063,644	7,262,220	0.559559				
46.	Total				58,368,685		15,419,448	

* 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: 14-0158	Medicaid Provider Number: 3042
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)	40,366,311	5,149,599	3,760,213	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	47,324	5,613	4,408	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	852.98	917.44	853.04	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	14,165			
3.	Program general inpatient routine cost (Line 1c X Line 2)	12,082,462			
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)	12,082,462			

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	6,928,239	4,253	1,629.02	1,064	1,733,277
9.	Coronary Care Unit	2,742,259	1,439	1,905.67	254	484,040
10.	NICU	1,907,696	2,795	682.54	2,145	1,464,048
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	1,732,223	3,839	451.22	2,947	1,329,745
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					15,419,448
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					32,513,020

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

Preliminary

Medicare Provider Number:	14-0158	Medicaid Provider Number:	3042
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)	Expense Allocation (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.	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 2552-10, W/S D-2, Col. 1)	Expense Allocation (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)	
		(1)	(2)	(3)	(4)	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0158	Medicaid Provider Number:	3042
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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic	198,925	4,688,496	0.042428	62,201		2,639	
7.	Nuclear Medicine	16,714	6,698,075	0.002495	279,222		697	
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.	MRI							
23.	GI Lab							
24.	Cardiac Catheterization	1,315,271	50,535,202	0.026027	4,944,269		128,684	
25.	EMG							
26.	Implant Supplies							
27.	Cardiac Rehab							
28.	Mercy Eye Center							
29.	Wound Care Center							
30.	CT Scan							
31.	Vein Clinic							
32.	Mental Health Center							
33.	Pre Birth Center	255,405	3,104,851	0.082260				
34.	Sleep Lab							
35.	Urology							
36.	Diabetes Center							
37.	ADDP OP							
38.	Mercy Clinic Polk St	190		#DIV/0!				
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	2,620,985	8,022,032	0.326723				
44.	Emergency	325,000	47,509,847	0.006841	3,627,332		24,815	
45.	Observation							
46.	Ancillary Total						156,835	

* 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:	14-0158	Medicaid Provider Number:	3042
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	920,555	47,324	19.45	14,165		275,509	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
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	1,655,700	3,839	431.28	2,947		1,270,982	
67.	Routine Total (lines 47-66)						1,546,491	
68.	Ancillary Total (from line 46)						156,835	
69.	Total (Lines 67-68)						1,703,326	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0158	Medicaid Provider Number: 3042
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)		32,513,020	
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)		1,703,326	
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)		3,166,459	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		37,382,805	
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)		58,368,685	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		15,637,089	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		2,416,524	
F. Coronary Care Unit		588,440	
G. NICU		4,043,796	
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		3,133,691	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		84,188,225	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			46,805,420
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: 14-0158	Medicaid Provider Number: 3042
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)	37,382,805	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	37,382,805	
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)	37,382,805	

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: 14-0158	Medicaid Provider Number: 3042
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)	46,805,420
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)	(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: 14-0158	Medicaid Provider Number: 3042
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

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:	14-0158	Medicaid Provider Number:	3042
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	1,161,411	27,356,102	0.042455	2,666,489		113,206	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,778,411	36,641,443	0.048536	2,054,383		99,712	
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.	MRI							
23.	GI Lab							
24.	Cardiac Catheterization							
25.	EMG							
26.	Implant Supplies							
27.	Cardiac Rehab							
28.	Mercy Eye Center							
29.	Wound Care Center							
30.	CT Scan							
31.	Vein Clinic							
32.	Mental Health Center							
33.	Pre Birth Center							
34.	Sleep Lab							
35.	Urology							
36.	Diabetes Center							
37.	ADDP OP							
38.	Mercy Clinic Polk St							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	1,682,594	47,509,847	0.035416	3,627,332		128,466	
45.	Observation							
46.	Ancillary Total						341,384	

* 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:	14-0158	Medicaid Provider Number:	3042
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	7,881,624	47,324	166.55	14,165		2,359,181	
48.	Psych							
49.	Rehab	177,115	4,408	40.18				
50.	Other (Sub)							
51.	Intensive Care Unit	528,442	4,253	124.25	1,064		132,202	
52.	Coronary Care Unit	198,892	1,439	138.22	254		35,108	
53.	NICU	389,073	2,795	139.20	2,145		298,584	
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)						2,825,075	
68.	Ancillary Total (from line 46)						341,384	
69.	Total (Lines 67-68)						3,166,459	

Preliminary

Medicare Provider Number: 14-0158	Medicaid Provider Number: 3042
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	17,628		17,628
Newborn Days	2,947		2,947
Total Inpatient Revenue	84,189,634	(1,409)	84,188,225
Ancillary Revenue	58,370,094	(1,409)	58,368,685
Routine Revenue	25,819,540		25,819,540
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]