

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: 07/01/2013	To: 06/30/2014	

Type of Control

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

Type of Hospital

☐ XXXX XXXX General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

☐ XXXX XXXX Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ 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 07/01/2013 and ending 06/30/2014 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: 07/01/2013 To: 06/30/2014

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	227,022		122,794	54.09%		36,596	4.57
2.	Psych	48	17,520		15,087	86.11%		2,879	5.24
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	63	22,995		10,000	43.49%			
6.	Coronary Care Unit	16	5,840		4,844	82.95%			
7.	NICU	98	35,770		26,349	73.66%			
8.	Burn ICU	9	3,285		3,280	99.85%			
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	120	43,800		18,998	43.37%			
22.	Total	976	356,232		201,352	56.52%		39,475	4.62
23.	Observation Bed Days				10,250				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				345			144	11.10
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				234				
6.	Coronary Care Unit				5				
7.	NICU				622				
8.	Burn ICU				393				
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				48				
22.	Total				1,647	0.82%		144	11.10

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: 07/01/2013 To: 06/30/2014

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	36,105,411	149,455,593	0.241580	674,607		162,972	
2.	Recovery Room	3,863,900	22,038,746	0.175323	32,466		5,692	
3.	Delivery and Labor Room	22,677,530	79,781,307	0.284246	230,562		65,536	
4.	Anesthesiology	3,242,756	55,299,037	0.058640	181,212		10,626	
5.	Radiology - Diagnostic	20,637,535	137,550,178	0.150036	273,971		41,106	
6.	Radiology - Therapeutic	11,723,945	69,466,786	0.168771	5,280		891	
7.	Nuclear Medicine	3,801,312	38,284,539	0.099291	11,960		1,188	
8.	Laboratory	35,048,038	261,975,553	0.133784	1,164,959		155,853	
9.	Blood							
10.	Blood - Administration	7,529,338	21,592,225	0.348706	488,835		170,460	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,008,353	77,222,675	0.194352	896,483		174,233	
13.	Physical Therapy	20,802,226	42,774,294	0.486325	243,113		118,232	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	13,455,559	134,462,967	0.100069	306,370		30,658	
17.	EEG							
18.	Med. / Surg. Supplies	48,105,936	452,648,415	0.106277	1,215,377		129,167	
19.	Drugs Charged to Patients	95,974,794	324,660,043	0.295616	2,768,800		818,502	
20.	Renal Dialysis	1,250,443	4,865,801	0.256986				
21.	Ambulance							
22.	Ultrasound	4,710,495	33,238,469	0.141718	52,034		7,374	
23.	CT Scan	2,746,581	125,416,879	0.021900	175,577		3,845	
24.	MRI	2,106,094	40,665,196	0.051791	22,015		1,140	
25.	Cardiac Rehab	1,814,349	1,829,862	0.991522				
26.	ASC	10,331,294	32,599,950	0.316911	11,932		3,781	
27.	Cardiac Cath Lab	5,642,338	47,564,814	0.118624	90,249		10,706	
28.	GI Lab	8,181,135	70,248,268	0.116460	9,065		1,056	
29.	Electroconvulsive Ther.	450,382	3,764,382	0.119643	9,654		1,155	
30.	OP Psych	2,491,649	6,186,345	0.402766				
31.	Implant Dev. Charged	60,627,571	101,176,994	0.599223	306,949		183,931	
32.	Hyperbaric/OP Wound	1,221,853	2,154,374	0.567150				
33.	Ambulatory Care Unit	2,424,369	26,563,896	0.091266				
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	6,238,056	19,455,499	0.320632				
44.	Emergency	24,755,905	117,281,103	0.211082				
45.	Observation	7,927,760	34,934,759	0.226930				
46.	Total				9,171,470		2,098,104	

* 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: 07/01/2013 To: 06/30/2014

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)	101,548,273	12,385,321		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	133,044	15,087		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	763.27	820.93		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	345			
3.	Program general inpatient routine cost (Line 1c X Line 2)	263,328			
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)	263,328			

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	27,666,082	10,000	2,766.61	234	647,387
9.	Coronary Care Unit	7,401,884	4,844	1,528.05	5	7,640
10.	NICU	26,993,045	26,349	1,024.44	622	637,202
11.	Burn ICU	4,134,676	3,280	1,260.57	393	495,404
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	9,868,674	18,998	519.46	48	24,934
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,098,104
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,173,999

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: 07/01/2013 To: 06/30/2014

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: 07/01/2013 To: 06/30/2014

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	1,018,230	149,455,593	0.006813	674,607		4,596	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	468,252	137,550,178	0.003404	273,971		933	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	114,576	261,975,553	0.000437	1,164,959		509	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	939	77,222,675	0.000012	896,483		11	
13.	Physical Therapy	1,427,637	42,774,294	0.033376	243,113		8,114	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,092,407	134,462,967	0.022998	306,370		7,046	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound	20,977	33,238,469	0.000631	52,034		33	
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC	140,003	32,599,950	0.004295	11,932		51	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	184,712	2,154,374	0.085738				
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	485,791	19,455,499	0.024969				
44.	Emergency	10,137,892	117,281,103	0.086441				
45.	Observation							
46.	Ancillary Total						21,293	

* 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: 07/01/2013 To: 06/30/2014

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	15,588,730	133,044	117.17	345		40,424	
48.	Psych	1,526,105	15,087	101.15				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,502,246	10,000	450.22	234		105,351	
52.	Coronary Care Unit							
53.	NICU	315,000	26,349	11.95	622		7,433	
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	37,500	18,998	1.97	48		95	
67.	Routine Total (lines 47-66)						153,303	
68.	Ancillary Total (from line 46)						21,293	
69.	Total (Lines 67-68)						174,596	

**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: 07/01/2013 To: 06/30/2014	
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)	4,173,999	
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)	174,596	
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)	84,187	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	4,432,782	
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)	9,171,470	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	591,195	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	244,148	
	F. Coronary Care Unit	37,034	
	G. NICU	3,064,231	
	H. Burn ICU	3,420,017	
	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	275	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	16,528,370	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		12,095,588
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: 07/01/2013 To: 06/30/2014

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)	4,432,782	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,432,782	
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)	4,432,782	

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: 07/01/2013 To: 06/30/2014

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)	12,095,588
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: 07/01/2013 To: 06/30/2014

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: 07/01/2013 To: 06/30/2014

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	2,456,196	149,455,593	0.016434	674,607		11,086	
2.	Recovery Room							
3.	Delivery and Labor Room	1,198,836	79,781,307	0.015027	230,562		3,465	
4.	Anesthesiology	124,133	55,299,037	0.002245	181,212		407	
5.	Radiology - Diagnostic	15,140	137,550,178	0.000110	273,971		30	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	122,097	77,222,675	0.001581	896,483		1,417	
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	168,492	70,248,268	0.002399	9,065		22	
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	54,983	19,455,499	0.002826				
44.	Emergency	482,811	117,281,103	0.004117				
45.	Observation							
46.	Ancillary Total						16,427	

* 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: 07/01/2013 To: 06/30/2014

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	9,439,816	133,044	70.95	345		24,478	
48.	Psych	198,773	15,087	13.18				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,759,916	10,000	175.99	234		41,182	
52.	Coronary Care Unit	1,806,842	4,844	373.01	5		1,865	
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	92,878	18,998	4.89	48		235	
67.	Routine Total (lines 47-66)						67,760	
68.	Ancillary Total (from line 46)						16,427	
69.	Total (Lines 67-68)						84,187	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2013 To: 06/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,599		1,599
Newborn Days	48		48
Total Inpatient Revenue	16,531,217	(2,847)	16,528,370
Ancillary Revenue	9,174,317	(2,847)	9,171,470
Routine Revenue	7,356,900		7,356,900
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

BHF Page 3- Removed \$2,847.00 of Medicaid charges for Cardiac Rehab as this is non-covered for IL Medicaid.

BHF page 7 - Included Psych R&B charges with Adults & Peds charges.

GME costs were adjusted to as filed W/S B Part 1, col 25 on BHF Supplement No. 2 (a) and (b).