

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. Mary's Health Center		Medicare Provider Number: 26-0091	
Street: 6420 Clayton Road		Medicaid Provider Number: 19035	
City: St. Louis	State: MO	Zip: 63117	
Period Covered by Statement:	From: 01/01/2017	To: 12/31/2017	

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	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

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. Mary's Health Center 19035 for the cost report beginning 01/01/2017 and ending 12/31/2017 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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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	259	94,535		52,049	55.06%		15,636	5.17
2.	Psych	46	16,790		14,786	88.06%		1,918	7.71
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	57	20,805		19,059	91.61%			
6.	Coronary Care Unit								
7.	PICU								
8.	NICU	27	9,855		9,747	98.90%			
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				6,347				
22.	Total	389	141,985		101,988	71.83%		17,554	5.45
23.	Observation Bed Days				6,161				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				957			245	9.08
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				47				
6.	Coronary Care Unit								
7.	PICU								
8.	NICU				1,221				
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				311				
22.	Total				2,536	2.49%		245	9.08

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:		
26-0091			19035		
Program:			Period Covered by Statement:		
Medicaid-Hospital			From:	01/01/2017	To: 12/31/2017

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	29,438,330	147,353,172	0.199781	338,216		67,569	
2.	Recovery Room	6,098,723	18,002,635	0.338768	27,490		9,313	
3.	Delivery and Labor Room	12,961,805	46,708,056	0.277507	636,652		176,675	
4.	Anesthesiology	2,476,506	49,569,716	0.049960	217,240		10,853	
5.	Radiology - Diagnostic	16,589,859	87,003,306	0.190681	188,191		35,884	
6.	Radiology - Therapeutic	7,253,507	41,774,540	0.173635	7,714		1,339	
7.	Nuclear Medicine	1,767,804	4,960,460	0.356379	1,243		443	
8.	Laboratory	25,665,531	206,112,443	0.124522	1,300,554		161,948	
9.	Blood							
10.	Blood - Administration	8,144,962	23,836,513	0.341701	232,675		79,505	
11.	Intravenous Therapy	6,202,806	45,418,772	0.136569	8,058		1,100	
12.	Respiratory Therapy	14,747,608	70,898,109	0.208011	470,053		97,776	
13.	Physical Therapy	3,355,451	9,112,983	0.368206	21,827		8,037	
14.	Occupational Therapy	1,378,765	5,715,752	0.241222	76,998		18,574	
15.	Speech Pathology	1,811,632	7,150,542	0.253356	2,659		674	
16.	EKG	6,249,000	58,512,195	0.106798	144,236		15,404	
17.	EEG	1,448,231	5,725,780	0.252932	5,465		1,382	
18.	Med. / Surg. Supplies	45,652,088	45,114,063	1.011926	358,549		362,825	
19.	Drugs Charged to Patients	56,276,821	231,992,980	0.242580	870,661		211,205	
20.	Renal Dialysis	2,490,035	8,945,517	0.278356	22,134		6,161	
21.	Ambulance							
22.	CT Scan	2,856,946	68,289,755	0.041836	110,675		4,630	
23.	MRI	2,861,272	34,718,871	0.082413	45,951		3,787	
24.	Ultrasound							
25.	Cardiac Catheterizat.	5,032,744	41,118,364	0.122397	56,734		6,944	
26.	Lab Stem Cell							
27.	Cardiac Rehab	1,411,962	1,053,750	1.339940				
28.	Vascular Lab							
29.	Endoscopy	5,076,980	23,454,247	0.216463	12,519		2,710	
30.	Clinical Nutrition	1,701,844	467,076	3.643613				
31.	ECT	204,340	748,925	0.272844				
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.	21,187,032	24,296,509	0.872020	87,763		76,531	
34.	Kidney Acquisition	322,741	40,000	8.068525				
35.	Heart Acquisition	146,239	82,000	1.783402				
36.	Liver Acquisition	177,190	138,000	1.283986				
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	24,860,832	37,053,530	0.670944	2,430		1,630	
44.	Emergency	26,737,641	116,140,436	0.230218	797,494		183,597	
45.	Observation	8,427,993	33,850,673	0.248976	2,993		745	
46.	Total				6,047,174		1,547,241	

* 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: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	57,081,344	11,161,757		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	58,210	14,786		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	980.61	754.89		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	957			
3.	Program general inpatient routine cost (Line 1c X Line 2)	938,444			
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)	938,444			

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	17,626,256	19,059	924.83	47	43,467
9.	Coronary Care Unit					
10.	PICU					
11.	NICU	10,413,527	9,747	1,068.38	1,221	1,304,492
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	7,552,125	6,347	1,189.87	311	370,050
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,547,241
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,203,694

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

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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.	PICU						
9.	NICU						
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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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	773,055	46,708,056	0.016551	636,652		10,537	
4.	Anesthesiology	3,980,000	49,569,716	0.080291	217,240		17,442	
5.	Radiology - Diagnostic	5,740	87,003,306	0.000066	188,191		12	
6.	Radiology - Therapeutic	108,543	41,774,540	0.002598	7,714		20	
7.	Nuclear Medicine							
8.	Laboratory	447,031	206,112,443	0.002169	1,300,554		2,821	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	4,824	9,112,983	0.000529	21,827		12	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	188,288	58,512,195	0.003218	144,236		464	
17.	EEG	3,092	5,725,780	0.000540	5,465		3	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Ultrasound							
25.	Cardiac Catheterizat.							
26.	Lab Stem Cell							
27.	Cardiac Rehab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	7,097,705	37,053,530	0.191553	2,430		465	
44.	Emergency	34,571	116,140,436	0.000298	797,494		238	
45.	Observation							
46.	Ancillary Total						32,014	

* 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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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	3,594,563	58,210	61.75	957		59,095	
48.	Psych	677,028	14,786	45.79				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,466,421	19,059	76.94	47		3,616	
52.	Coronary Care Unit							
53.	PICU							
54.	NICU	239,097	9,747	24.53	1,221		29,951	
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)						92,662	
68.	Ancillary Total (from line 46)						32,014	
69.	Total (Lines 67-68)						124,676	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 26-0091		Medicaid Provider Number: 19035	
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/2017 To: 12/31/2017	
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)	4,203,694	
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)	124,676	
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)	628,267	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	4,956,637	
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)	6,047,174	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,862,705	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	192,365	
	F. Coronary Care Unit		
	G. PICU		
	H. NICU	3,471,420	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	387,260	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	11,960,924	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		7,004,287
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: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	4,956,637	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,956,637	
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)	4,956,637	

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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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)	7,004,287
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: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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:		Medicaid Provider Number:	
26-0091		19035	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2017	To: 12/31/2017

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	6,438,841	147,353,172	0.043697	338,216		14,779	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	2,372,205	49,569,716	0.047856	217,240		10,396	
5.	Radiology - Diagnostic	2,033,318	87,003,306	0.023371	188,191		4,398	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	338,886	4,960,460	0.068317	1,243		85	
8.	Laboratory	1,016,659	206,112,443	0.004933	1,300,554		6,416	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	677,773	58,512,195	0.011583	144,236		1,671	
17.	EEG	2,711,090	5,725,780	0.473488	5,465		2,588	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	77,424	8,945,517	0.008655	22,134		192	
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Ultrasound							
25.	Cardiac Catheterizat.							
26.	Lab Stem Cell							
27.	Cardiac Rehab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	2,372,205	116,140,436	0.020425	797,494		16,289	
45.	Observation							
46.	Ancillary Total						56,814	

* 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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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	34,758,977	58,210	597.13	957		571,453	
48.	Psych	338,886	14,786	22.92				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	PICU							
54.	NICU							
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)						571,453	
68.	Ancillary Total (from line 46)						56,814	
69.	Total (Lines 67-68)						628,267	

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,225		2,225
Newborn Days	311		311
Total Inpatient Revenue	11,960,923	1	11,960,924
Ancillary Revenue	6,047,173	1	6,047,174
Routine Revenue	5,913,750		5,913,750
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]