

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: 07/01/2019	To: 06/30/2020	

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)) Mercy Hospital and Medical C 3042 for the cost report beginning 07/01/2019 and ending 06/30/2020 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: 07/01/2019 To: 06/30/2020

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	168	61,320		30,151	49.17%		9,053	4.11
2.	Psych	39	14,235		6,930	48.68%		1,272	5.45
3.	Rehab	16	5,840		2,725	46.66%		259	10.52
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,110		4,809	94.11%			
6.	Coronary Care Unit	6	2,190		1,235	56.39%			
7.	NICU	15	5,475		1,041	19.01%			
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	25	9,125		3,234	35.44%			
22.	Total	283	103,295		50,125	48.53%		10,584	4.43
23.	Observation Bed Days				6,787				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				125			13	9.62
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	NICU								
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								
22.	Total				125	0.25%		13	9.62

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: 07/01/2019	To: 06/30/2020

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	10,928,925	17,040,425	0.641353				
2.	Recovery Room	1,223,857	2,004,735	0.610483				
3.	Delivery and Labor Room	7,042,733	11,082,454	0.635485				
4.	Anesthesiology	549,557	4,415,097	0.124472				
5.	Radiology - Diagnostic	7,579,946	43,147,280	0.175676	3,261		573	
6.	Radiology - Therapeutic	1,207,045	6,091,162	0.198163				
7.	Nuclear Medicine	1,190,711	6,903,420	0.172481				
8.	Laboratory	15,765,960	102,927,833	0.153175	19,104		2,926	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,972,556	14,179,650	0.209635	4,881		1,023	
13.	Physical Therapy	2,271,128	3,802,470	0.597277	46,385		27,705	
14.	Occupational Therapy	1,138,901	2,291,035	0.497112	49,527		24,620	
15.	Speech Pathology	698,600	1,700,973	0.410706	26,043		10,696	
16.	EKG							
17.	EEG	277,861	326,608	0.850748				
18.	Med. / Surg. Supplies	3,375,229	6,110,552	0.552361	1,171		647	
19.	Drugs Charged to Patients	23,368,082	59,278,659	0.394207	17,088		6,736	
20.	Renal Dialysis	1,173,744	1,636,031	0.717434	1,640		1,177	
21.	Ambulance							
22.	MRI	975,961	8,126,988	0.120089				
23.	GI Lab	1,608,256	4,983,532	0.322714				
24.	Cardiac Catheterization	5,646,584	30,225,908	0.186813	909		170	
25.	EMG							
26.	Implant Supplies	4,968,770	7,049,952	0.704795				
27.	Cardiac Rehab	410,098	1,023,267	0.400773				
28.	Mercy Eye Center	799,227	900,551	0.887487				
29.	Wound Care Center	566,183	902,461	0.627377				
30.	Mercy Clinics							
31.	Mental Health Center	577,384	512,491	1.126623				
32.	CT Scan	1,882,808	40,808,759	0.046137	2,217		102	
33.	Pre-Birth Center	623,343	3,364,048	0.185296				
34.	Sleep Lab	686,066	1,702,316	0.403019				
35.	Urology	191,157	8,696	21.982176				
36.	ADDP OP	166,972	202,963	0.822672				
37.	Diabetes Treatment	245,253	110,704	2.215394				
38.	Vein Clinic							
39.	Psych Partial Hospital	140,546	983,645	0.142883				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	11,545,649	629,224	18.349028				
44.	Emergency	13,525,894	64,030,354	0.211242				
45.	Observation	8,119,288	9,200,562	0.882477				
46.	Total				172,226		76,375	

* 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: 07/01/2019 To: 06/30/2020

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)	44,188,918	8,012,794	4,032,367	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	36,938	6,930	2,725	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,196.30	1,156.25	1,479.77	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			125	
3.	Program general inpatient routine cost (Line 1c X Line 2)			184,971	
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)			184,971	

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	9,276,269	4,809	1,928.94		
9.	Coronary Care Unit	2,320,966	1,235	1,879.32		
10.	NICU	2,557,228	1,041	2,456.51		
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	1,133,176	3,234	350.39		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					76,375
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					261,346

**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:	To:
		07/01/2019	06/30/2020

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 (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:	14-0158	Medicaid Provider Number:	3042
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	709,824	43,147,280	0.016451	3,261		54	
6.	Radiology - Therapeutic	931,525	6,091,162	0.152931				
7.	Nuclear Medicine							
8.	Laboratory	966	102,927,833	0.000009	19,104			
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	3,831	4,983,532	0.000769				
24.	Cardiac Catheterization	2,012,760	30,225,908	0.066591	909		61	
25.	EMG							
26.	Implant Supplies							
27.	Cardiac Rehab							
28.	Mercy Eye Center							
29.	Wound Care Center							
30.	Mercy Clinics							
31.	Mental Health Center							
32.	CT Scan							
33.	Pre-Birth Center	796,644	3,364,048	0.236811				
34.	Sleep Lab							
35.	Urology							
36.	ADDP OP							
37.	Diabetes Treatment							
38.	Vein Clinic							
39.	Psych Partial Hospital							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total						115	

* 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: 07/01/2019 To: 06/30/2020

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							
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	479,952	3,234	148.41				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						115	
69.	Total (Lines 67-68)						115	

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: 07/01/2019 To: 06/30/2020

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)		261,346	
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)		115	
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)		123	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		261,584	
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)		172,226	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics			
B. Psych			
C. Rehab		231,875	
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. NICU			
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			
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		404,101	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			142,517
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: 07/01/2019 To: 06/30/2020

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)	261,584	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	261,584	
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)	261,584	

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:	Medicaid Provider Number:
14-0158	3042
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2019 To: 06/30/2020

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)	142,517
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(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: 14-0158	Medicaid Provider Number: 3042
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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:	14-0158	Medicaid Provider Number:	3042
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	1,060,279	17,040,425	0.062221				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,623,552	43,147,280	0.037628	3,261		123	
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.	Mercy Clinics							
31.	Mental Health Center							
32.	CT Scan							
33.	Pre-Birth Center							
34.	Sleep Lab							
35.	Urology							
36.	ADDP OP							
37.	Diabetes Treatment							
38.	Vein Clinic							
39.	Psych Partial Hospital							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	1,536,079	64,030,354	0.023990				
45.	Observation							
46.	Ancillary Total						123	

* 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: 07/01/2019 To: 06/30/2020

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	7,195,316	36,938	194.79				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	482,427	4,809	100.32				
52.	Coronary Care Unit	181,573	1,235	147.02				
53.	NICU	355,193	1,041	341.20				
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)							
68.	Ancillary Total (from line 46)						123	
69.	Total (Lines 67-68)						123	

Preliminary

Medicare Provider Number: 14-0158	Medicaid Provider Number: 3042
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	125		125
Newborn Days			
Total Inpatient Revenue	404,101		404,101
Ancillary Revenue	172,226		172,226
Routine Revenue	231,875		231,875
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Costs and Charges adjusted to agree with W/S C columns 1 & 8

BHF Page 2 , Col 2 changed the bed days available to agree with W/S S-3, col 3.

BHF Page 2. Col 7 changed the discharge days to agree with W/S S-3. col 7.

BHF Page 2, col 4, line 21 - changed the nursery I/P days to agree with W/S S-3.

BHF Page 6a - didn't include the clinic professional as doesn't tie to W/S A-8-2

BHF Page 4 - Changed the nursery total days to agree with W/S S-3

BHF Page 6a - changed col 2, line 8 to agree with W/S C Part I

BHF Supplemental 2a and 2b - added the GME expenses from W/S B Part I of Medicare report.

BHF Page 6b - changed the nursery total days to agree with W/S S-3