

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: 07/01/2020	To: 06/30/2021

Type of Control

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

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-St. Louis 19029 for the cost report beginning 07/01/2020 and ending 06/30/2021 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: 07/01/2020 To: 06/30/2021			

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	624	227,760		155,789	68.40%		37,800	5.67
2.	Psych	16	5,840		4,061	69.54%		583	6.97
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	65	23,725		21,648	91.25%			
6.	Coronary Care Unit	16	5,840		4,228	72.40%			
7.	Burn ICU	12	4,380		3,171	72.40%			
8.	Neonatal ICU	126	45,990		29,648	64.47%			
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	220	80,300		16,606	20.68%			
22.	Total	1,079	393,835		235,151	59.71%		38,383	5.69
23.	Observation Bed Days				15,485				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				143			60	5.27
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				124				
6.	Coronary Care Unit				27				
7.	Burn ICU				13				
8.	Neonatal ICU				9				
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				27				
22.	Total				343	0.15%		60	5.27

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: 07/01/2020 To: 06/30/2021

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	46,238,718	303,067,378	0.152569	141,357		21,567	
2.	Recovery Room	3,860,339	65,997,450	0.058492	13,633		797	
3.	Delivery and Labor Room	26,234,933	54,456,958	0.481755	16,681		8,036	
4.	Anesthesiology	6,989,193	100,359,249	0.069642	38,116		2,654	
5.	Radiology - Diagnostic	21,451,344	112,135,517	0.191298	37,822		7,235	
6.	Radiology - Therapeutic	11,337,734	119,771,864	0.094661	23,216		2,198	
7.	Nuclear Medicine	2,935,658	45,896,375	0.063963	14,555		931	
8.	Laboratory	78,666,391	451,101,474	0.174387	358,549		62,526	
9.	Blood							
10.	Blood - Administration	5,506,705	28,569,229	0.192750	45,618		8,793	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,682,220	79,089,688	0.185640	324,702		60,278	
13.	Physical Therapy	26,006,099	72,220,317	0.360094	30,993		11,160	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	12,094,278	164,857,234	0.073362	103,566		7,598	
17.	EEG							
18.	Med. / Surg. Supplies	65,087,981	224,195,419	0.290318	193,139		56,072	
19.	Drugs Charged to Patients	206,297,160	#####	0.191443	471,983		90,358	
20.	Renal Dialysis	2,229,318	10,014,798	0.222602				
21.	Ambulance							
22.	Ultrasound	5,067,548	62,460,812	0.081132	9,381		761	
23.	CT Scan	3,030,510	241,477,948	0.012550	129,090		1,620	
24.	MRI	3,897,952	106,329,958	0.036659	26,766		981	
25.	Cardiac Rehab	1,682,641	2,554,347	0.658736				
26.	ASC	9,918,897	29,066,699	0.341246	2,733		933	
27.	Cardiac Cath Lab	4,037,517	101,128,301	0.039925	25,269		1,009	
28.	GI Lab	9,955,897	95,005,931	0.104792	7,765		814	
29.	Electroconvulsive Ther.	272,053	1,069,336	0.254413				
30.	OP Psych	1,291,476	6,901,520	0.187129				
31.	Implant Dev. Charged	80,985,058	135,486,400	0.597736	156,390		93,480	
32.	Hyperbaric/OP Wound	1,752,894	2,945,916	0.595025				
33.	Ambulatory Care Unit	2,215,676	5,254,036	0.421709				
34.	Covid 19							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	17,513,692	17,710,638	0.988880				
44.	Emergency	28,380,209	168,096,966	0.168832				
45.	Observation	15,997,244	53,866,651	0.296979				
46.	Total				2,171,324		439,801	

* 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: 07/01/2020 To: 06/30/2021

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)	176,405,658	4,515,404		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	171,274	4,061		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,029.96	1,111.89		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	143			
3.	Program general inpatient routine cost (Line 1c X Line 2)	147,284			
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)	147,284			

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	37,523,087	21,648	1,733.33	124	214,933
9.	Coronary Care Unit	7,092,901	4,228	1,677.60	27	45,295
10.	Burn ICU	5,198,709	3,171	1,639.45	13	21,313
11.	Neonatal ICU	32,397,535	29,648	1,092.74	9	9,835
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,719,322	16,606	525.07	27	14,177
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					439,801
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					892,638

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: 07/01/2020 To: 06/30/2021

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.	Burn ICU						
9.	Neonatal ICU						
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:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	8,278	303,067,378	0.000027	141,357		4	
2.	Recovery Room							
3.	Delivery and Labor Room	616,414	54,456,958	0.011319	16,681		189	
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	706,646	451,101,474	0.001566	358,549		561	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,562	79,089,688	0.000146	324,702		47	
13.	Physical Therapy	1,714,630	72,220,317	0.023742	30,993		736	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,336,933	164,857,234	0.008110	103,566		840	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	16,795	241,477,948	0.000070	129,090		9	
24.	MRI	1,600	106,329,958	0.000015	26,766			
25.	Cardiac Rehab							
26.	ASC	810,456	29,066,699	0.027883	2,733		76	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	472,117	2,945,916	0.160262				
33.	Ambulatory Care Unit							
34.	Covid 19							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	295,029	17,710,638	0.016658				
44.	Emergency	12,055,946	168,096,966	0.071720				
45.	Observation							
46.	Ancillary Total						2,462	

* 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: 07/01/2020 To: 06/30/2021	

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	22,205,999	171,274	129.65	143		18,540	
48.	Psych	2,672,136	4,061	658.00				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,016,790	21,648	231.74	124		28,736	
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Neonatal ICU	21,611	29,648	0.73	9		7	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	1,068	16,606	0.06	27		2	
67.	Routine Total (lines 47-66)						47,285	
68.	Ancillary Total (from line 46)						2,462	
69.	Total (Lines 67-68)						49,747	

**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: 07/01/2020 To: 06/30/2021

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)		892,638	
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)		49,747	
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)		25,409	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		967,794	
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)		2,171,324	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		271,494	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		576,694	
F. Coronary Care Unit		99,098	
G. Burn ICU		54,630	
H. Neonatal ICU		47,215	
I. Other			
J. Other			
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		25,542	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		3,245,997	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			2,278,203
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: 07/01/2020 To: 06/30/2021

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)	967,794	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	967,794	
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)	967,794	

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: 07/01/2020 To: 06/30/2021

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)	2,278,203
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)	(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: 07/01/2020 To: 06/30/2021

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	2,694,262	303,067,378	0.008890	141,357		1,257	
2.	Recovery Room							
3.	Delivery and Labor Room	1,651,891	54,456,958	0.030334	16,681		506	
4.	Anesthesiology	749,742	100,359,249	0.007471	38,116		285	
5.	Radiology - Diagnostic	28,465	112,135,517	0.000254	37,822		10	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	106,821	79,089,688	0.001351	324,702		439	
13.	Physical Therapy	115,013	72,220,317	0.001593	30,993		49	
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	305,337	62,460,812	0.004888	9,381		46	
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Lab	135,915	95,005,931	0.001431	7,765		11	
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound							
33.	Ambulatory Care Unit							
34.	Covid 19							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	487,364	17,710,638	0.027518				
44.	Emergency	640,611	168,096,966	0.003811				
45.	Observation							
46.	Ancillary Total						2,603	

* 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: 07/01/2020 To: 06/30/2021

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	9,680,267	171,274	56.52	143		8,082	
48.	Psych	249,039	4,061	61.32				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,364,830	21,648	63.05	124		7,818	
52.	Coronary Care Unit	1,044,051	4,228	246.94	27		6,667	
53.	Burn ICU							
54.	Neonatal ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	147,260	16,606	8.87	27		239	
67.	Routine Total (lines 47-66)						22,806	
68.	Ancillary Total (from line 46)						2,603	
69.	Total (Lines 67-68)						25,409	

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	316		316
Newborn Days	27		27
Total Inpatient Revenue	3,246,287	(290)	3,245,997
Ancillary Revenue	2,171,614	(290)	2,171,324
Routine Revenue	1,074,673		1,074,673
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]