Hospital Statement of Cost

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:** 07/01/2014	**To:** 06/30/2015

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 07/01/2014 and ending 06/30/2015 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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	610	212,943		121,799	57.20%		37,991	4.51
2.	Psych	48	17,520		15,839	90.41%		3,044	5.20
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	22,122		15,607	70.55%			
6.	Coronary Care Unit	16	5,840		5,071	86.83%			
7.	NICU	98	35,770		25,494	71.27%			
8.	Burn ICU	9	3,285		3,225	98.17%			
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	100	36,500		18,916	51.82%			
22.	**Total**	**947**	**333,980**		**205,951**	**61.67%**		**41,035**	**4.56**
23.	Observation Bed Days				12,364				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				367			218	4.04
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				97				
6.	Coronary Care Unit				12				
7.	NICU				214				
8.	Burn ICU				190				
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				35				
22.	**Total**				**915**	**0.44%**		**218**	**4.04**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	40,113,693	157,706,864	0.254356	333,384		84,798	
2.	Recovery Room	3,710,664	23,050,136	0.160982	31,697		5,103	
3.	Delivery and Labor Room	23,971,426	80,457,630	0.297939	93,938		27,988	
4.	Anesthesiology	3,149,464	60,734,961	0.051856	93,554		4,851	
5.	Radiology - Diagnostic	21,473,053	146,771,388	0.146303	112,213		16,417	
6.	Radiology - Therapeutic	11,759,815	81,582,156	0.144147	7,657		1,104	
7.	Nuclear Medicine	3,597,504	39,405,944	0.091293	14,294		1,305	
8.	Laboratory	39,029,428	258,739,708	0.150844	576,711		86,993	
9.	Blood							
10.	Blood - Administration	7,483,611	19,712,775	0.379633	75,875		28,805	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,624,613	84,203,078	0.185559	531,924		98,703	
13.	Physical Therapy	22,899,983	50,235,047	0.455857	140,292		63,953	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	12,970,193	139,043,769	0.093281	152,327		14,209	
17.	EEG							
18.	Med. / Surg. Supplies	50,219,606	157,838,308	0.318171	534,504		170,064	
19.	Drugs Charged to Patients	133,295,158	441,195,676	0.302123	1,303,167		393,717	
20.	Renal Dialysis	1,339,957	5,377,242	0.249190				
21.	Ambulance							
22.	Ultrasound	4,660,203	34,387,085	0.135522	10,824		1,467	
23.	CT Scan	2,835,304	134,324,560	0.021108	173,103		3,654	
24.	MRI	1,658,665	42,096,894	0.039401	8,412		331	
25.	Cardiac Rehab	1,759,502	2,178,875	0.807528				
26.	ASC	10,734,791	35,378,695	0.303425	9,658		2,930	
27.	Cardiac Cath Lab	5,949,759	46,702,161	0.127398	10,112		1,288	
28.	GI Lab	8,604,983	72,980,886	0.117907	10,169		1,199	
29.	Electroconvulsive Ther.	469,772	4,199,333	0.111868				
30.	OP Psych	2,256,781	8,223,318	0.274437				
31.	Implant Dev. Charged	66,973,442	110,665,445	0.605188	153,533		92,916	
32.	Hyperbaric/OP Wound	1,567,420	3,584,245	0.437308				
33.	Ambulatory Care Unit	2,433,293	22,230,345	0.109458				
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	8,042,847	26,640,317	0.301905				
44.	Emergency	32,774,820	137,933,071	0.237614				
45.	Observation	9,299,459	38,927,908	0.238889				
46.	**Total**				**4,377,348**		**1,101,795**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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)	99,697,862	12,174,758		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	134,163	15,839		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	743.11	768.66		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	367			
3.	Program general inpatient routine cost (Line 1c X Line 2)	272,721			
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)	272,721			

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	25,151,041	15,607	1,611.52	97	156,317
9.	Coronary Care Unit	7,212,751	5,071	1,422.35	12	17,068
10.	NICU	26,592,695	25,494	1,043.10	214	223,223
11.	Burn ICU	4,078,767	3,225	1,264.73	190	240,299
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	8,758,367	18,916	463.01	35	16,205
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,101,795
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,027,628**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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	631,232	146,771,388	0.004301	112,213		483	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	117,076	258,739,708	0.000452	576,711		261	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	1,486,146	50,235,047	0.029584	140,292		4,150	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,809,980	139,043,769	0.013017	152,327		1,983	
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	153,745	35,378,695	0.004346	9,658		42	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	247,877	3,584,245	0.069157				
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	518,345	26,640,317	0.019457				
44.	Emergency	12,268,874	137,933,071	0.088948				
45.	Observation							
46.	**Ancillary Total**						**6,919**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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	2,578,637	134,163	19.22	367		7,054	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,717,678	15,607	238.21	97		23,106	
52.	Coronary Care Unit							
53.	NICU	503,655	25,494	19.76	214		4,229	
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							
67.	**Routine Total (lines 47-66)**						**34,389**	
68.	**Ancillary Total (from line 46)**						**6,919**	
69.	**Total (Lines 67-68)**						**41,308**	

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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)	2,027,628	
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)	41,308	
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)	50,626	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,119,562**	
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)	4,377,348	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,098,629	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	255,048	
	F. Coronary Care Unit	29,130	
	G. NICU	1,068,044	
	H. Burn ICU	1,050,803	
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	7,879,002	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,759,440
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	2,119,562	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,119,562	
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)**	**2,119,562**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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)	5,759,440
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
26-0020	**19029**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2014 To: 06/30/2015**

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:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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	2,548,345	157,706,864	0.016159	333,384		5,387	
2.	Recovery Room							
3.	Delivery and Labor Room	1,140,804	80,457,630	0.014179	93,938		1,332	
4.	Anesthesiology	31,381	60,734,961	0.000517	93,554		48	
5.	Radiology - Diagnostic	62,671	146,771,388	0.000427	112,213		48	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	124,892	84,203,078	0.001483	531,924		789	
13.	Physical Therapy	136,705	50,235,047	0.002721	140,292		382	
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	202,443	72,980,886	0.002774	10,169		28	
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	219,396	26,640,317	0.008235				
44.	Emergency	559,897	137,933,071	0.004059				
45.	Observation							
46.	**Ancillary Total**						**8,014**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the 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:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

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	9,373,595	134,163	69.87	367		25,642	
48.	Psych	217,412	15,839	13.73				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,349,919	15,607	86.49	97		8,390	
52.	Coronary Care Unit	2,044,717	5,071	403.22	12		4,839	
53.	NICU	86,297	25,494	3.38	214		723	
54.	Burn ICU	47,793	3,225	14.82	190		2,816	
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	108,932	18,916	5.76	35		202	
67.	**Routine Total (lines 47-66)**						**42,612**	
68.	**Ancillary Total (from line 46)**						**8,014**	
69.	**Total (Lines 67-68)**						**50,626**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2014 To: 06/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	880		880
Newborn Days	35		35
Total Inpatient Revenue	7,882,332	(3,330)	7,879,002
Ancillary Revenue	4,380,678	(3,330)	4,377,348
Routine Revenue	3,501,654		3,501,654
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 $3,330 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).