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:	Medicare Provider Number:
Mercy Hospital-St. Louis	26-0020
Street:	**Medicaid Provider Number:**
615 South New Ballas Road	19029

City:	State:	Zip:
St. Louis	MO.	63141

Period Covered by Statement:	From:	To:
	07/01/2015	06/30/2016

Type of Contrc

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 Hospita

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 07/01/2015 and ending 06/30/2016 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: 07/01/2015 To: 06/30/2016

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	579	211,914		127,551	60.19%		39,163	4.68
2.	Psych	48	17,568		15,836	90.14%		2,995	5.29
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,156		17,852	73.90%			
6.	Coronary Care Unit	16	5,856		5,804	99.11%			
7.	Burn ICU	9	3,294		2,897	87.95%			
8.	Neonatal ICU	98	35,868		29,219	81.46%			
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	120	43,920		18,854	42.93%			
22.	**Total**	**936**	**342,576**		**218,013**	**63.64%**		**42,158**	**4.72**
23.	Observation Bed Days				14,382				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				268			99	5.79
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				57				
6.	Coronary Care Unit				3				
7.	Burn ICU				133				
8.	Neonatal ICU				112				
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				26				
22.	**Total**				**599**	**0.27%**		**99**	**5.79**

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: 07/01/2015 To: 06/30/2016

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	44,631,674	172,866,285	0.258186	142,697		36,842	
2.	Recovery Room	3,846,784	24,075,441	0.159780	25,097		4,010	
3.	Delivery and Labor Room	26,667,108	83,110,004	0.320865	75,800		24,322	
4.	Anesthesiology	3,689,568	72,070,554	0.051194	53,655		2,747	
5.	Radiology - Diagnostic	24,637,591	166,545,956	0.147933	61,344		9,075	
6.	Radiology - Therapeutic	11,799,662	84,423,532	0.139767	7,750		1,083	
7.	Nuclear Medicine	3,828,868	42,150,723	0.090838	6,215		565	
8.	Laboratory	44,385,029	284,170,911	0.156191	365,110		57,027	
9.	Blood							
10.	Blood - Administration	7,826,445	20,373,129	0.384155	21,269		8,171	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,960,671	92,308,668	0.162072	125,388		20,322	
13.	Physical Therapy	25,974,179	58,245,547	0.445943	70,795		31,571	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	14,634,794	145,247,056	0.100758	65,059		6,555	
17.	EEG							
18.	Med. / Surg. Supplies	58,136,438	172,270,561	0.337472	219,375		74,033	
19.	Drugs Charged to Patients	154,135,352	491,562,755	0.313562	425,084		133,290	
20.	Renal Dialysis	1,341,154	5,681,393	0.236061				
21.	Ambulance							
22.	Ultrasound	5,577,729	34,284,560	0.162689	17,856		2,905	
23.	CT Scan	3,476,398	148,893,796	0.023348	144,380		3,371	
24.	MRI	2,261,845	47,880,155	0.047240	17,214		813	
25.	Cardiac Rehab	1,943,187	2,253,279	0.862382				
26.	ASC	13,439,413	44,997,183	0.298672	7,848		2,344	
27.	Cardiac Cath Lab	6,186,829	48,379,493	0.127881	62,488		7,991	
28.	GI Lab	10,501,185	78,071,099	0.134508	9,736		1,310	
29.	Electroconvulsive Ther.	431,259	5,143,506	0.083845				
30.	OP Psych	2,613,025	8,614,202	0.303339				
31.	Implant Dev. Charged	69,166,924	113,432,966	0.609760	44,415		27,082	
32.	Hyperbaric/OP Wound	1,804,179	4,316,941	0.417930				
33.	Ambulatory Care Unit	2,986,162	11,754,126	0.254052				
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	9,099,640	27,562,007	0.330152				
44.	Emergency	36,155,056	151,141,264	0.239214	462		111	
45.	Observation	12,141,716	44,876,108	0.270561				
46.	**Total**				**1,969,037**		**455,540**	

* 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: 07/01/2015 To: 06/30/2016

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)	118,636,187	13,754,007		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	141,933	15,836		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	835.86	868.53		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	268			
3.	Program general inpatient routine cost (Line 1c X Line 2)	224,010			
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)	224,010			

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	28,460,852	17,852	1,594.27	57	90,873
9.	Coronary Care Unit	8,849,067	5,804	1,524.65	3	4,574
10.	Burn ICU	4,625,241	2,897	1,596.56	133	212,342
11.	Neonatal ICU	30,897,366	29,219	1,057.44	112	118,433
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,825,325	18,854	468.09	26	12,170
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					455,540
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,117,942**

Hospital Statement of Cos

Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Progra

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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.	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 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: 07/01/2015 To: 06/30/2016

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	287,217	172,866,285	0.001661	142,697		237	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	505,500	166,545,956	0.003035	61,344		186	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	105,026	284,170,911	0.000370	365,110		135	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	1,444,086	58,245,547	0.024793	70,795		1,755	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,698,888	145,247,056	0.011697	65,059		761	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	11,585	148,893,796	0.000078	144,380		11	
24.	MRI							
25.	Cardiac Rehab							
26.	ASC	129,910	44,997,183	0.002887	7,848		23	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	389,439	4,316,941	0.090212				
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	489,319	27,562,007	0.017753				
44.	Emergency	13,231,949	151,141,264	0.087547	462		40	
45.	Observation							
46.	**Ancillary Total**						**3,148**	

* 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: 07/01/2015 To: 06/30/2016

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	2,248,104	141,933	15.84	268		4,245	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,607,062	17,852	202.05	57		11,517	
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Neonatal ICU	105,009	29,219	3.59	112		402	
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)**						**16,164**	
68.	**Ancillary Total (from line 46)**						**3,148**	
69.	**Total (Lines 67-68)**						**19,312**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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)	1,117,942	
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)	19,312	
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)	29,953	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,167,207**	
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)	1,969,037	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	524,010	
	B. Psych	62,708	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	315,228	
	F. Coronary Care Unit	6,502	
	G. Burn ICU	284,036	
	H. Neonatal ICU	423,621	
	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)**	3,585,142	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,417,935
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: 07/01/2015 To: 06/30/2016

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)	1,167,207	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,167,207	
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)**	**1,167,207**	

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.

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: 07/01/2015 To: 06/30/2016

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charge

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)	2,417,935
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 Charge

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: 07/01/2015 To: 06/30/2016

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

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: 07/01/2015 To: 06/30/2016

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	1,942,446	172,866,285	0.011237	142,697		1,603	
2.	Recovery Room							
3.	Delivery and Labor Room	1,136,217	83,110,004	0.013671	75,800		1,036	
4.	Anesthesiology	45,574	72,070,554	0.000632	53,655		34	
5.	Radiology - Diagnostic	23,012	166,545,956	0.000138	61,344		8	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	171,061	92,308,668	0.001853	125,388		232	
13.	Physical Therapy	90,699	58,245,547	0.001557	70,795		110	
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	139,870	78,071,099	0.001792	9,736		17	
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	327,292	27,562,007	0.011875				
44.	Emergency	460,510	151,141,264	0.003047	462		1	
45.	Observation							
46.	**Ancillary Total**						**3,041**	

* 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: 07/01/2015 To: 06/30/2016

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	9,364,981	141,933	65.98	268		17,683	
48.	Psych	224,906	15,836	14.20				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,232,490	17,852	69.04	57		3,935	
52.	Coronary Care Unit	2,934,208	5,804	505.55	3		1,517	
53.	Burn ICU	72,272	2,897	24.95	133		3,318	
54.	Neonatal ICU	86,026	29,219	2.94	112		329	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	94,295	18,854	5.00	26		130	
67.	**Routine Total (lines 47-66)**						**26,912**	
68.	**Ancillary Total (from line 46)**						**3,041**	
69.	**Total (Lines 67-68)**						**29,953**	

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: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	573		573
Newborn Days	26		26
Total Inpatient Revenue	3,585,422	(280)	3,585,142
Ancillary Revenue	1,969,317	(280)	1,969,037
Routine Revenue	1,616,105		1,616,105
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 $280 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).

The Hospital is using Old Cost Report Format for their Cost Report.