

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: 07/01/2016	To: 06/30/2017

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab _____	<input type="checkbox"/> _____
<input type="checkbox"/> Medicaid Sub I Psych _____	<input type="checkbox"/> Medicaid Sub III Other _____	<input type="checkbox"/> _____

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 07/01/2016 and ending 06/30/2017 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____
 Email Address _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____
 Email Address _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	630	229,950		131,750	57.30%		37,728	4.97
2.	Psych	40	14,600		11,790	80.75%		2,385	4.94
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	63	22,995		16,763	72.90%			
6.	Coronary Care Unit	19	6,935		6,898	99.47%			
7.	Burn ICU	9	3,285		2,950	89.80%			
8.	Neonatal ICU	98	35,770		29,075	81.28%			
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	43,800		19,421	44.34%			
22.	Total	979	357,335		218,647	61.19%		40,113	4.97
23.	Observation Bed Days				17,081				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				293			86	7.94
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				69				
6.	Coronary Care Unit				1				
7.	Burn ICU				187				
8.	Neonatal ICU				133				
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				16				
22.	Total				699	0.32%		86	7.94

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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	44,686,276	213,698,896	0.209109	367,805		76,911	
2.	Recovery Room	4,124,673	67,632,465	0.060987	34,433		2,100	
3.	Delivery and Labor Room	26,809,125	63,227,089	0.424013	89,444		37,925	
4.	Anesthesiology	3,425,827	86,172,409	0.039755	113,096		4,496	
5.	Radiology - Diagnostic	24,047,796	94,618,254	0.254156	88,264		22,433	
6.	Radiology - Therapeutic	11,239,989	91,182,216	0.123270				
7.	Nuclear Medicine	4,721,268	46,229,342	0.102127	7,291		745	
8.	Laboratory	47,406,359	337,615,169	0.140415	549,376		77,141	
9.	Blood							
10.	Blood - Administration	8,429,949	19,056,683	0.442362	70,995		31,405	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,525,605	64,625,482	0.224766	155,908		35,043	
13.	Physical Therapy	26,969,635	54,690,667	0.493130	100,601		49,609	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	14,075,226	134,781,506	0.104430	183,588		19,172	
17.	EEG							
18.	Med. / Surg. Supplies	62,006,955	205,791,923	0.301309	406,463		122,471	
19.	Drugs Charged to Patients	155,470,247	598,493,171	0.259769	965,538		250,817	
20.	Renal Dialysis	1,694,392	6,667,486	0.254128				
21.	Ambulance							
22.	Ultrasound	5,568,595	46,942,436	0.118626	17,127		2,032	
23.	CT Scan	3,524,754	186,470,800	0.018902	125,374		2,370	
24.	MRI	2,405,921	82,272,555	0.029243	29,501		863	
25.	Cardiac Rehab	1,865,201	2,171,241	0.859048				
26.	ASC	13,521,983	22,583,147	0.598764	9,193		5,504	
27.	Cardiac Cath Lab	6,341,554	65,147,291	0.097342	23,965		2,333	
28.	GI Lab	10,247,202	77,681,629	0.131913	4,918		649	
29.	Electroconvulsive Ther.	363,440	1,665,258	0.218248				
30.	OP Psych	2,795,352	7,802,890	0.358246				
31.	Implant Dev. Charged	69,930,689	114,066,823	0.613068	143,612		88,044	
32.	Hyperbaric/OP Wound	1,769,266	2,359,894	0.749723				
33.	Ambulatory Care Unit	2,795,060	6,376,290	0.438352				
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	11,355,069	11,248,597	1.009465				
44.	Emergency	34,526,671	144,169,185	0.239487				
45.	Observation	15,286,129	58,936,288	0.259367				
46.	Total				3,486,492		832,063	

* 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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	132,346,431	7,688,613		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	148,831	11,790		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	889.24	652.13		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	293			
3.	Program general inpatient routine cost (Line 1c X Line 2)	260,547			
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)	260,547			

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	27,917,886	16,763	1,665.45	69	114,916
9.	Coronary Care Unit	8,656,109	6,898	1,254.87	1	1,255
10.	Burn ICU	4,548,121	2,950	1,541.74	187	288,305
11.	Neonatal ICU	31,783,822	29,075	1,093.17	133	145,392
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,910,711	19,421	458.82	16	7,341
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					832,063
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,649,819

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: 07/01/2016 To: 06/30/2017

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	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)	
						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

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	2,271,951	213,698,896	0.010632	367,805		3,911	
2.	Recovery Room	7,465	67,632,465	0.000110	34,433		4	
3.	Delivery and Labor Room	240,825	63,227,089	0.003809	89,444		341	
4.	Anesthesiology							
5.	Radiology - Diagnostic	519,868	94,618,254	0.005494	88,264		485	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	97,176	337,615,169	0.000288	549,376		158	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,857	64,625,482	0.000168	155,908		26	
13.	Physical Therapy	2,310,398	54,690,667	0.042245	100,601		4,250	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	495,984	134,781,506	0.003680	183,588		676	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	21,105	186,470,800	0.000113	125,374		14	
24.	MRI							
25.	Cardiac Rehab							
26.	ASC	502,674	22,583,147	0.022259	9,193		205	
27.	Cardiac Cath Lab	1,454	65,147,291	0.000022	23,965		1	
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	486,423	2,359,894	0.206121				
33.	Ambulatory Care Unit	4,224	6,376,290	0.000662				
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	397,371	11,248,597	0.035326				
44.	Emergency	16,871,799	144,169,185	0.117028				
45.	Observation							
46.	Ancillary Total						10,071	

* 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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	2,431,406	148,831	16.34	293		4,788	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,386,469	16,763	261.68	69		18,056	
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Neonatal ICU	87,978	29,075	3.03	133		403	
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)						23,247	
68.	Ancillary Total (from line 46)						10,071	
69.	Total (Lines 67-68)						33,318	

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

Preliminary

Medicare Provider Number: 26-0020		Medicaid Provider Number: 19029	
Program: Medicaid Hospital		Period Covered by Statement: From: 07/01/2016 To: 06/30/2017	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	1,649,819	
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)	33,318	
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)	29,060	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,712,197	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	3,486,492	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	570,621	
	B. Psych	92,941	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	338,118	
	F. Coronary Care Unit	8,893	
	G. Burn ICU	421,468	
	H. Neonatal ICU	735,614	
	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)	5,654,147	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,941,950
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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	1,712,197	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,712,197	
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)	1,712,197	

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.

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	3,941,950
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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 07/01/2016 To: 06/30/2017

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	2,373,626	213,698,896	0.011107	367,805		4,085	
2.	Recovery Room							
3.	Delivery and Labor Room	1,111,541	63,227,089	0.017580	89,444		1,572	
4.	Anesthesiology	233,509	86,172,409	0.002710	113,096		306	
5.	Radiology - Diagnostic	20,085	94,618,254	0.000212	88,264		19	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	126,299	64,625,482	0.001954	155,908		305	
13.	Physical Therapy	107,209	54,690,667	0.001960	100,601		197	
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	88,120	46,942,436	0.001877	17,127		32	
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Lab	140,775	77,681,629	0.001812	4,918		9	
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	375,821	11,248,597	0.033410				
44.	Emergency	453,175	144,169,185	0.003143				
45.	Observation							
46.	Ancillary Total						6,525	

* 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: 07/01/2016 To: 06/30/2017

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	8,674,915	148,831	58.29	293		17,079	
48.	Psych	183,567	11,790	15.57				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,105,388	16,763	65.94	69		4,550	
52.	Coronary Care Unit	2,970,742	6,898	430.67	1		431	
53.	Burn ICU							
54.	Neonatal ICU	86,582	29,075	2.98	133		396	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	95,357	19,421	4.91	16		79	
67.	Routine Total (lines 47-66)						22,535	
68.	Ancillary Total (from line 46)						6,525	
69.	Total (Lines 67-68)						29,060	

