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:** 07/01/2017	**To:** 06/30/2018	

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		
	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 07/01/2017 and ending 06/30/2018 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: 07/01/2017 To: 06/30/2018

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	654	238,710		145,032	60.76%		44,964	4.39
2.	Psych	16	5,840		4,083	69.91%		533	7.66
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		17,048	70.77%			
6.	Coronary Care Unit	16	5,840		4,655	79.71%			
7.	Burn ICU	9	3,285		2,639	80.33%			
8.	Neonatal ICU	98	35,770		28,093	78.54%			
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		18,489	42.21%			
22.	**Total**	**979**	**357,335**		**220,039**	**61.58%**		**45,497**	**4.43**
23.	Observation Bed Days				17,797				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				190			88	5.58
2.	Psych				11			88	0.13
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				9				
6.	Coronary Care Unit				1				
7.	Burn ICU				110				
8.	Neonatal ICU				181				
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				35				
22.	**Total**				**537**	**0.24%**		**176**	**2.85**

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: 07/01/2017 To: 06/30/2018

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	47,760,359	234,887,107	0.203333	155,832		31,686	
2.	Recovery Room	4,334,442	67,567,251	0.064150	20,180		1,295	
3.	Delivery and Labor Room	26,587,885	57,107,343	0.465577	83,286		38,776	
4.	Anesthesiology	3,598,764	89,005,926	0.040433	53,591		2,167	
5.	Radiology - Diagnostic	24,838,066	99,590,623	0.249402	44,737		11,157	
6.	Radiology - Therapeutic	11,620,643	94,940,904	0.122399				
7.	Nuclear Medicine	4,269,819	47,712,006	0.089492	4,073		365	
8.	Laboratory	49,772,120	357,085,270	0.139384	312,563		43,566	
9.	Blood							
10.	Blood - Administration	8,458,852	19,634,491	0.430816	12,546		5,405	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,125,029	70,106,417	0.215744	75,892		16,373	
13.	Physical Therapy	30,022,162	58,970,562	0.509104	60,112		30,603	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	13,688,124	147,539,189	0.092776	123,668		11,473	
17.	EEG							
18.	Med. / Surg. Supplies	67,230,154	219,158,971	0.306764	164,806		50,557	
19.	Drugs Charged to Patients	134,228,824	603,297,849	0.222492	363,803		80,943	
20.	Renal Dialysis	1,835,540	7,244,506	0.253370	203		51	
21.	Ambulance							
22.	Ultrasound	5,263,878	48,933,248	0.107573	15,730		1,692	
23.	CT Scan	3,500,559	199,405,226	0.017555	87,953		1,544	
24.	MRI	2,611,006	87,558,342	0.029820	37,346		1,114	
25.	Cardiac Rehab	1,922,763	2,257,734	0.851634				
26.	ASC	13,690,791	23,123,390	0.592075	3,798		2,249	
27.	Cardiac Cath Lab	6,841,509	75,695,907	0.090381	24,470		2,212	
28.	GI Lab	10,674,958	75,763,456	0.140899	2,403		339	
29.	Electroconvulsive Ther.	404,842	1,419,232	0.285254				
30.	OP Psych	2,830,501	7,841,927	0.360945				
31.	Implant Dev. Charged	75,281,343	120,968,810	0.622320	39,227		24,412	
32.	Hyperbaric/OP Wound	2,072,586	2,230,864	0.929051				
33.	Ambulatory Care Unit	2,640,397	5,494,156	0.480583				
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	13,428,108	11,109,961	1.208655				
44.	Emergency	36,037,176	142,043,722	0.253705				
45.	Observation	15,489,263	59,354,163	0.260963				
46.	**Total**				**1,686,219**		**357,979**	

* 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: 07/01/2017 To: 06/30/2018

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)	141,460,463	8,915,193		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	162,829	4,083		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	868.77	2,183.49		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	190	11		
3.	Program general inpatient routine cost (Line 1c X Line 2)	165,066	24,018		
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)	165,066	24,018		

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	29,628,806	17,048	1,737.96	9	15,642
9.	Coronary Care Unit	7,226,505	4,655	1,552.42	1	1,552
10.	Burn ICU	4,440,049	2,639	1,682.47	110	185,072
11.	Neonatal ICU	31,382,639	28,093	1,117.10	181	202,195
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,131,290	18,489	439.79	35	15,393
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					357,979
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**966,917**

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: 07/01/2017 To: 06/30/2018

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: 07/01/2017 To: 06/30/2018

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	2,503,583	234,887,107	0.010659	155,832		1,661	
2.	Recovery Room	3,700	67,567,251	0.000055	20,180		1	
3.	Delivery and Labor Room	360,841	57,107,343	0.006319	83,286		526	
4.	Anesthesiology							
5.	Radiology - Diagnostic	473,194	99,590,623	0.004751	44,737		213	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	97,176	357,085,270	0.000272	312,563		85	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	30,351	70,106,417	0.000433	75,892		33	
13.	Physical Therapy	2,331,124	58,970,562	0.039530	60,112		2,376	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,082,524	147,539,189	0.014115	123,668		1,746	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	14,810	199,405,226	0.000074	87,953		7	
24.	MRI							
25.	Cardiac Rehab							
26.	ASC	499,125	23,123,390	0.021585	3,798		82	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	496,418	2,230,864	0.222523				
33.	Ambulatory Care Unit	2,212	5,494,156	0.000403				
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	357,842	11,109,961	0.032209				
44.	Emergency	16,921,533	142,043,722	0.119129				
45.	Observation							
46.	**Ancillary Total**						**6,730**	

* 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: 07/01/2017 To: 06/30/2018

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	2,580,465	162,829	15.85	190		3,012	
48.	Psych	38,844	4,083	9.51	11		105	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,011,520	17,048	235.31	9		2,118	
52.	Coronary Care Unit							
53.	Burn ICU	3,190	2,639	1.21	110		133	
54.	Neonatal ICU	57,568	28,093	2.05	181		371	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	345	18,489	0.02	35		1	
67.	**Routine Total (lines 47-66)**						**5,740**	
68.	**Ancillary Total (from line 46)**						**6,730**	
69.	**Total (Lines 67-68)**						**12,470**	

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: 07/01/2017 To: 06/30/2018

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)	966,917	
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)	12,470	
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)	18,466	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**997,853**	
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)	1,686,219	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	329,453	
	B. Psych	43,582	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	96,105	
	F. Coronary Care Unit	3,603	
	G. Burn ICU	386,701	
	H. Neonatal ICU	839,829	
	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)**	3,385,492	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,387,639
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: 07/01/2017 To: 06/30/2018

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)	997,853	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	997,853	
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)**	**997,853**	

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: 07/01/2017 To: 06/30/2018

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)	2,387,639
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: 07/01/2017 To: 06/30/2018**

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: 07/01/2017 To: 06/30/2018

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	2,878,437	234,887,107	0.012255	155,832		1,910	
2.	Recovery Room							
3.	Delivery and Labor Room	1,571,206	57,107,343	0.027513	83,286		2,291	
4.	Anesthesiology	724,594	89,005,926	0.008141	53,591		436	
5.	Radiology - Diagnostic	79,181	99,590,623	0.000795	44,737		36	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	178,528	70,106,417	0.002547	75,892		193	
13.	Physical Therapy	117,461	58,970,562	0.001992	60,112		120	
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	87,612	48,933,248	0.001790	15,730		28	
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Lab	179,212	75,763,456	0.002365	2,403		6	
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	697,934	2,230,864	0.312854				
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	481,125	11,109,961	0.043306				
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**						**5,020**	

* 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: 07/01/2017 To: 06/30/2018

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	9,599,384	162,829	58.95	190		11,201	
48.	Psych	317,523	4,083	77.77	11		855	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,635,121	17,048	95.91	9		863	
52.	Coronary Care Unit	1,419,224	4,655	304.88	1		305	
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	117,461	18,489	6.35	35		222	
67.	**Routine Total (lines 47-66)**						**13,446**	
68.	**Ancillary Total (from line 46)**						**5,020**	
69.	**Total (Lines 67-68)**						**18,466**	

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: 07/01/2017 To: 06/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	502		502
Newborn Days	35		35
Total Inpatient Revenue	3,385,492		3,385,492
Ancillary Revenue	1,686,219		1,686,219
Routine Revenue	1,699,273		1,699,273
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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

GME costs were adjusted to as filed W/S B Part 1, col 25 on BHF Supplement No. 2 (a) and (b).