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:** 07/01/2018	**To:** 06/30/2019	

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 07/01/2018 and ending 06/30/2019 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

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:	Medicaid Provider Number:
26-0020	19029
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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		155,234	65.03%		41,026	5.12
2.	Psych	16	5,840		4,560	78.08%		1,095	4.16
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		17,354	72.04%			
6.	Coronary Care Unit	16	5,840		3,788	64.86%			
7.	Burn ICU	9	3,285		2,721	82.83%			
8.	Neonatal ICU	98	35,770		31,141	87.06%			
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		17,974	41.04%			
22.	**Total**	**979**	**357,335**		**232,772**	**65.14%**		**42,121**	**5.10**
23.	Observation Bed Days				16,607				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				203			70	5.01
2.	Psych				3			70	0.04
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				45				
6.	Coronary Care Unit				1				
7.	Burn ICU				69				
8.	Neonatal ICU				33				
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				29				
22.	**Total**				**383**	**0.16%**		**140**	**2.53**

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: 07/01/2018 To: 06/30/2019

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	45,638,510	260,259,187	0.175358	177,525		31,130	
2.	Recovery Room	4,158,091	70,620,895	0.058879	12,820		755	
3.	Delivery and Labor Room	26,037,183	52,966,654	0.491577	21,777		10,705	
4.	Anesthesiology	3,870,598	94,359,382	0.041020	91,945		3,772	
5.	Radiology - Diagnostic	24,651,013	110,106,027	0.223884	36,165		8,097	
6.	Radiology - Therapeutic	11,775,686	108,947,770	0.108086				
7.	Nuclear Medicine	3,473,046	51,969,701	0.066828	1,753		117	
8.	Laboratory	52,273,417	398,134,083	0.131296	351,809		46,191	
9.	Blood							
10.	Blood - Administration	8,205,616	19,547,714	0.419774	48,542		20,377	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,029,972	77,391,812	0.194206	148,146		28,771	
13.	Physical Therapy	30,324,124	65,486,473	0.463059	45,448		21,045	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	13,339,719	163,443,112	0.081617	61,439		5,014	
17.	EEG							
18.	Med. / Surg. Supplies	69,655,753	233,252,608	0.298628	287,161		85,754	
19.	Drugs Charged to Patients	143,203,277	664,491,483	0.215508	393,970		84,904	
20.	Renal Dialysis	1,681,071	7,836,866	0.214508	18,193		3,903	
21.	Ambulance							
22.	Ultrasound	4,846,495	56,031,870	0.086495	5,166		447	
23.	CT Scan	3,659,050	223,565,402	0.016367	68,889		1,128	
24.	MRI	2,846,207	102,292,215	0.027824	7,029		196	
25.	Cardiac Rehab	2,012,083	2,763,017	0.728220				
26.	ASC	12,325,435	26,729,673	0.461114	4,096		1,889	
27.	Cardiac Cath Lab	5,569,119	85,140,434	0.065411	4,096		268	
28.	GI Lab	11,070,440	80,383,034	0.137721	4,939		680	
29.	Electroconvulsive Ther.	298,887	1,581,396	0.189002				
30.	OP Psych	2,773,893	8,009,107	0.346342				
31.	Implant Dev. Charged	77,917,025	127,087,139	0.613099	72,916		44,705	
32.	Hyperbaric/OP Wound	2,285,551	3,372,366	0.677729				
33.	Ambulatory Care Unit	2,876,829	5,620,031	0.511888				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	13,378,210	12,710,152	1.052561				
44.	Emergency	40,915,417	161,421,616	0.253469	23,257		5,895	
45.	Observation	14,836,362	58,408,819	0.254009				
46.	**Total**				**1,887,081**		**405,743**	

* 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: 07/01/2018 To: 06/30/2019

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)	153,333,061	5,047,977		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	171,841	4,560		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	892.30	1,107.01		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	203	3		
3.	Program general inpatient routine cost (Line 1c X Line 2)	181,137	3,321		
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)	181,137	3,321		

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	44,712,360	17,354	2,576.49	45	115,942
9.	Coronary Care Unit	6,998,195	3,788	1,847.46	1	1,847
10.	Burn ICU	4,577,701	2,721	1,682.36	69	116,083
11.	Neonatal ICU	34,501,831	31,141	1,107.92	33	36,561
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,893,321	17,974	494.79	29	14,349
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					405,743
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**874,983**

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: 07/01/2018 To: 06/30/2019

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: 07/01/2018 To: 06/30/2019

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	2,246,302	260,259,187	0.008631	177,525		1,532	
2.	Recovery Room	3,931	70,620,895	0.000056	12,820		1	
3.	Delivery and Labor Room	477,377	52,966,654	0.009013	21,777		196	
4.	Anesthesiology							
5.	Radiology - Diagnostic	735,297	110,106,027	0.006678	36,165		242	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	97,176	398,134,083	0.000244	351,809		86	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,876	77,391,812	0.000257	148,146		38	
13.	Physical Therapy	1,467,256	65,486,473	0.022405	45,448		1,018	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,861,440	163,443,112	0.011389	61,439		700	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	13,295	223,565,402	0.000059	68,889		4	
24.	MRI	1,400	102,292,215	0.000014	7,029			
25.	Cardiac Rehab							
26.	ASC	399,563	26,729,673	0.014948	4,096		61	
27.	Cardiac Cath Lab							
28.	GI Lab							
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound	461,860	3,372,366	0.136954				
33.	Ambulatory Care Unit	1,244	5,620,031	0.000221				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	301,851	12,710,152	0.023749				
44.	Emergency	16,147,791	161,421,616	0.100035	23,257		2,327	
45.	Observation							
46.	**Ancillary Total**						**6,205**	

* 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: 07/01/2018 To: 06/30/2019

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	2,483,239	171,841	14.45	203		2,933	
48.	Psych	3,946	4,560	0.87	3		3	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,643,420	17,354	209.95	45		9,448	
52.	Coronary Care Unit							
53.	Burn ICU	1,923	2,721	0.71	69		49	
54.	Neonatal ICU	23,837	31,141	0.77	33		25	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	7,467	17,974	0.42	29		12	
67.	**Routine Total (lines 47-66)**						**12,470**	
68.	**Ancillary Total (from line 46)**						**6,205**	
69.	**Total (Lines 67-68)**						**18,675**	

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: 07/01/2018 To: 06/30/2019

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)	874,983	
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)	18,675	
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)	22,316	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**915,974**	
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)	1,887,081	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	357,446	
	B. Psych	950	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	227,223	
	F. Coronary Care Unit	3,674	
	G. Burn ICU	288,201	
	H. Neonatal ICU	143,726	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	31,022	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	2,939,323	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,023,349
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: 07/01/2018 To: 06/30/2019

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)	915,974	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	915,974	
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)**	**915,974**	

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: 07/01/2018 To: 06/30/2019

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)	2,023,349
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost **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: 07/01/2018 To: 06/30/2019**

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: 07/01/2018 To: 06/30/2019

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	3,252,830	260,259,187	0.012498	177,525		2,219	
2.	Recovery Room							
3.	Delivery and Labor Room	1,760,099	52,966,654	0.033230	21,777		724	
4.	Anesthesiology	815,611	94,359,382	0.008644	91,945		795	
5.	Radiology - Diagnostic	79,711	110,106,027	0.000724	36,165		26	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	201,165	77,391,812	0.002599	148,146		385	
13.	Physical Therapy	124,860	65,486,473	0.001907	45,448		87	
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	117,194	56,031,870	0.002092	5,166		11	
23.	CT Scan							
24.	MRI							
25.	Cardiac Rehab							
26.	ASC							
27.	Cardiac Cath Lab							
28.	GI Lab	148,470	80,383,034	0.001847	4,939		9	
29.	Electroconvulsive Ther.							
30.	OP Psych							
31.	Implant Dev. Charged							
32.	Hyperbaric/OP Wound							
33.	Ambulatory Care Unit							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	764,986	12,710,152	0.060187				
44.	Emergency	837,760	161,421,616	0.005190	23,257		121	
45.	Observation							
46.	**Ancillary Total**						**4,377**	

* 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: 07/01/2018 To: 06/30/2019

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	10,713,199	171,841	62.34	203		12,655	
48.	Psych	364,725	4,560	79.98	3		240	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,713,976	17,354	98.77	45		4,445	
52.	Coronary Care Unit	1,505,266	3,788	397.38	1		397	
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	125,470	17,974	6.98	29		202	
67.	**Routine Total (lines 47-66)**						**17,939**	
68.	**Ancillary Total (from line 46)**						**4,377**	
69.	**Total (Lines 67-68)**						**22,316**	

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: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	354		354
Newborn Days	29		29
Total Inpatient Revenue	2,940,132	(809)	2,939,323
Ancillary Revenue	1,887,890	(809)	1,887,081
Routine Revenue	1,052,242		1,052,242
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 - Removed $811 of Cardiac Rehab charges as they are not covered by IL Medicaid
BHF Page 7 - Removed $182 of Services of Teaching Physicians

GME costs were adjusted to positive numbers
$2 Minor adjustment ($811 Cardiac Rehab charges vs $809) due to rounding.