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: St. Mary's Health Center		**Medicare Provider Number:** 26-0091	
Street: 6420 Clayton Road		**Medicaid Provider Number:** 19035	
City: St. Louis	**State:** MO	**Zip:** 63117	
Period Covered by Statement:	**From:** 01/01/2016	**To:** 12/31/2016	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
XXXX XXXX	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

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

XXXX XXXX	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) St. Mary's Health Center 19035 for the cost report beginning 01/01/2016 and ending 12/31/2016 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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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	259	94,794		52,441	55.32%		19,158	4.25
2.	Psych	46	16,836		15,157	90.03%		2,019	7.51
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	57	20,862		19,502	93.48%			
6.	Coronary Care Unit								
7.	PICU								
8.	NICU	27	9,882		9,519	96.33%			
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				6,514				
22.	**Total**	**389**	**142,374**		**103,133**	**72.44%**		**21,177**	**4.56**
23.	Observation Bed Days				6,523				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,028			299	9.79
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				37				
6.	Coronary Care Unit								
7.	PICU								
8.	NICU				1,861				
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				229				
22.	**Total**				**3,155**	**3.06%**		**299**	**9.79**

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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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	27,906,337	138,768,304	0.201100	527,090		105,998	
2.	Recovery Room	5,735,199	23,165,356	0.247577	37,162		9,200	
3.	Delivery and Labor Room	5,504,218	41,447,889	0.132799	127,968		16,994	
4.	Anesthesiology	2,612,771	45,826,861	0.057014	219,079		12,491	
5.	Radiology - Diagnostic	16,225,096	90,506,530	0.179270	247,919		44,444	
6.	Radiology - Therapeutic	6,952,994	40,955,096	0.169771	25,505		4,330	
7.	Nuclear Medicine	1,817,745	5,357,180	0.339310	3,295		1,118	
8.	Laboratory	25,546,006	226,573,070	0.112750	1,318,971		148,714	
9.	Blood							
10.	Blood - Administration	4,583,481	23,092,660	0.198482	209,995		41,680	
11.	Intravenous Therapy	5,965,735	13,619,093	0.438042	9,337		4,090	
12.	Respiratory Therapy	14,068,862	77,211,245	0.182213	902,201		164,393	
13.	Physical Therapy	1,499,221	11,151,797	0.134438	28,596		3,844	
14.	Occupational Therapy	756,035	6,232,651	0.121302	132,178		16,033	
15.	Speech Pathology	1,438,919	7,258,252	0.198246	4,087		810	
16.	EKG	5,832,144	52,658,970	0.110753	150,389		16,656	
17.	EEG	853,999	4,677,349	0.182582	3,057		558	
18.	Med. / Surg. Supplies	46,868,375	48,237,497	0.971617	564,656		548,629	
19.	Drugs Charged to Patients	61,650,957	248,702,713	0.247890	823,736		204,196	
20.	Renal Dialysis	2,824,838	10,001,224	0.282449	11,259		3,180	
21.	Ambulance							
22.	CT Scan	2,801,106	78,376,209	0.035739	125,588		4,488	
23.	MRI	3,224,129	33,570,528	0.096040	52,741		5,065	
24.	Ultrasound							
25.	Cardiac Catheterizat.	5,653,156	43,532,386	0.129861	15,955		2,072	
26.	Lab Stem Cell							
27.	Cardiac Rehab	1,156,958	864,501	1.338296				
28.	Vascular Lab							
29.	Endoscopy	4,624,321	23,034,026	0.200760	27,435		5,508	
30.	Clinical Nutrition	1,591,915	381,784	4.169674				
31.	ECT	406,084	640,510	0.634001				
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.	21,898,325	26,365,008	0.830583	110,951		92,154	
34.	Kidney Acquisition	499,948	369,753	1.352113				
35.	Heart Acquisition	552,782	328,000	1.685311				
36.	Liver Acquisition	261,871	207,000	1.265077				
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	23,707,745	41,170,451	0.575844	103		59	
44.	Emergency	25,300,975	133,246,602	0.189881	1,249,260		237,211	
45.	Observation	7,518,900	40,812,454	0.184231	3,112		573	
46.	**Total**				**6,931,625**		**1,694,488**	

* 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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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)	48,863,661	11,833,286		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	58,964	15,157		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	828.70	780.71		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,028			
3.	Program general inpatient routine cost (Line 1c X Line 2)	851,904			
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)	851,904			

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	18,176,830	19,502	932.05	37	34,486
9.	Coronary Care Unit					
10.	PICU					
11.	NICU	8,754,692	9,519	919.71	1,861	1,711,580
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,123,913	6,514	479.57	229	109,822
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,694,488
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**4,402,280**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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.	PICU						
9.	NICU						
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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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							
2.	Recovery Room							
3.	Delivery and Labor Room	4,266,118	41,447,889	0.102927	127,968		13,171	
4.	Anesthesiology	3,770,000	45,826,861	0.082266	219,079		18,023	
5.	Radiology - Diagnostic	36,631	90,506,530	0.000405	247,919		100	
6.	Radiology - Therapeutic	108,893	40,955,096	0.002659	25,505		68	
7.	Nuclear Medicine							
8.	Laboratory	426,510	226,573,070	0.001882	1,318,971		2,482	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	1,171,775	11,151,797	0.105075	28,596		3,005	
14.	Occupational Therapy	363,334	6,232,651	0.058295	132,178		7,705	
15.	Speech Pathology	237,572	7,258,252	0.032731	4,087		134	
16.	EKG	211,703	52,658,970	0.004020	150,389		605	
17.	EEG	310,969	4,677,349	0.066484	3,057		203	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Ultrasound							
25.	Cardiac Catheterizat.							
26.	Lab Stem Cell							
27.	Cardiac Rehab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	6,709,984	41,170,451	0.162981	103		17	
44.	Emergency	69,710	133,246,602	0.000523	1,249,260		653	
45.	Observation							
46.	**Ancillary Total**						**46,166**	

* 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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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	12,433,123	58,964	210.86	1,028		216,764	
48.	Psych	596,615	15,157	39.36				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,393,071	19,502	71.43	37		2,643	
52.	Coronary Care Unit							
53.	PICU							
54.	NICU	212,955	9,519	22.37	1,861		41,631	
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)**						**261,038**	
68.	**Ancillary Total (from line 46)**						**46,166**	
69.	**Total (Lines 67-68)**						**307,204**	

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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)	4,402,280	
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)	307,204	
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)	842,975	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**5,552,459**	
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)	6,931,625	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,238,701	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	133,617	
	F. Coronary Care Unit		
	G. PICU		
	H. NICU	5,710,833	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	293,712	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	15,308,488	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		9,756,029
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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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)	5,552,459	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,552,459	
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)**	**5,552,459**	

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:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

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)	9,756,029
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 Charge

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 Questionnair

PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
26-0091	**19035**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 01/01/2016 To: 12/31/2016**

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 Questionnair

		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:**
26-0091	**19035**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 01/01/2016 To: 12/31/2016**

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	8,702,551	138,768,304	0.062713	527,090		33,055	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,481,020	45,826,861	0.075960	219,079		16,641	
5.	Radiology - Diagnostic	2,610,765	90,506,530	0.028846	247,919		7,151	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	435,128	5,357,180	0.081223	3,295		268	
8.	Laboratory	1,740,510	226,573,070	0.007682	1,318,971		10,132	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	870,255	52,658,970	0.016526	150,389		2,485	
17.	EEG	3,481,020	4,677,349	0.744229	3,057		2,275	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	127,615	10,001,224	0.012760	11,259		144	
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Ultrasound							
25.	Cardiac Catheterizat.							
26.	Lab Stem Cell							
27.	Cardiac Rehab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Psychotherapy							
33.	Impl Dev Chrgd to P.							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Anatomic Pathology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	3,045,893	133,246,602	0.022859	1,249,260		28,557	
45.	Observation							
46.	**Ancillary Total**						**100,708**	

* 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:**
26-0091	**19035**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 01/01/2016 To: 12/31/2016**

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	42,574,667	58,964	722.05	1,028		742,267	
48.	Psych	435,128	15,157	28.71				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	PICU							
54.	NICU							
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)**						**742,267**	
68.	**Ancillary Total (from line 46)**						**100,708**	
69.	**Total (Lines 67-68)**						**842,975**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenu

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2016 To: 12/31/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,926		2,926
Newborn Days	229		229
Total Inpatient Revenue	15,308,488		15,308,488
Ancillary Revenue	6,931,625		6,931,625
Routine Revenue	8,376,863		8,376,863
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Adults & Peds and NICU days utilized split between St. Mary's and Cardinal Glennon.

Adults & Peds and NICU costs from W/S C allocated between St. Mary's and Cardinal Glennon based upon split of days. See worksheet.

Adults & Peds and NICU Pro Fee costs from W/S A-8-2, Column 4 allocated between St. Mary's and Cardinal Glennon based upon split of days.