

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Cardinal Glennon Children's Hospital		Medicare Provider Number: 26-0091
Street: 1465 South Grand Boulevard		Medicaid Provider Number: 19026
City: St. Louis	State: MO	Zip: 63104
Period Covered by Statement:	From: 01/01/2011	To: 12/31/2011

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☒ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) Children's Hospital

Health Care Program

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

☒ 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)) Cardinal Glennon Children's H 19026 for the cost report beginning 01/01/2011 and ending 12/31/2011 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
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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	101	36,865		22,655	61.45%		5,740	8.21
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU	19	6,935		4,559	65.74%			
8.	NICU	60	21,900		19,883	90.79%			
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								
22.	Total	180	65,700		47,097	71.68%		5,740	8.21
23.	Observation Bed Days				1,250				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,007			1,861	6.67
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU				752				
8.	NICU				6,656				
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								
22.	Total				12,415	26.36%		1,861	6.67

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
26-0091		19026	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2011	To: 12/31/2011

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	31,720,706	107,285,589	0.295666	4,253,615		1,257,649	
2.	Recovery Room	7,969,059	28,873,006	0.276004	328,873		90,770	
3.	Delivery and Labor Room	7,039,505	22,233,694	0.316614				
4.	Anesthesiology	3,411,095	29,238,029	0.116666	1,183,185		138,037	
5.	Radiology - Diagnostic	15,357,662	132,338,166	0.116049	3,170,493		367,933	
6.	Radiology - Therapeutic	4,041,079	21,656,402	0.186600	9,754		1,820	
7.	Nuclear Medicine	2,138,802	10,483,896	0.204008	83,233		16,980	
8.	Laboratory	12,880,559	159,457,989	0.080777	7,267,426		587,041	
9.	Blood							
10.	Blood - Administration	7,041,294	20,503,227	0.343424	1,054,426		362,115	
11.	Intravenous Therapy	4,641,404	8,104,301	0.572709	98,476		56,398	
12.	Respiratory Therapy	9,458,119	50,770,632	0.186291	4,545,098		846,711	
13.	Physical Therapy	3,451,469	8,168,500	0.422534	552,127		233,292	
14.	Occupational Therapy	976,072	3,993,863	0.244393	303,659		74,212	
15.	Speech Pathology	1,720,103	2,687,122	0.640128	119,232		76,324	
16.	EKG	3,281,273	29,078,452	0.112842	699,026		78,879	
17.	EEG	1,312,208	2,156,952	0.608362	43,844		26,673	
18.	Med. / Surg. Supplies	22,169,969	28,659,875	0.773554	2,991,879		2,314,380	
19.	Drugs Charged to Patients	38,481,160	153,987,717	0.249898	5,993,258		1,497,703	
20.	Renal Dialysis	1,841,704	6,069,518	0.303435	4,428		1,344	
21.	Ambulance							
22.	Pain Management	832,153	984,547	0.845214	26,465		22,369	
23.	Ultrasound	1,488,207	12,937,667	0.115029	188,388		21,670	
24.	Cardiac Catheterization	5,425,806	35,945,557	0.150945	485,520		73,287	
25.	Anatomic Pathology	4,379,701	15,360,526	0.285127	480,248		136,932	
26.	Lab Stem Cell	108,416	120,598	0.898987	836		752	
27.	Sleep Disorder	1,505,654	8,420,514	0.178808	182,435		32,621	
28.	Vascular Lab	1,113,708	11,011,352	0.101142	226,319		22,890	
29.	Endoscopy	5,428,609	30,547,520	0.177710	221,361		39,338	
30.	Clinical Nutrition	1,166,993	281,286	4.148777	994		4,124	
31.	Psychotherapy	1,890,618	7,211,915	0.262152				
32.	Implants	17,214,272	22,120,240	0.778214	900,250		700,587	
33.	ECT	515,867	1,370,333	0.376454				
34.	Kidney Acquisition	585,663	284,400	2.059293				
35.	Heart Acquisition	191,203	108,925	1.755364				
36.	Liver Acquisition	191,434	110,350	1.734789				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	21,756,430	29,537,064	0.736581				
44.	Emergency	22,204,314	105,060,231	0.211348				
45.	Observation	4,168,563	18,926,556	0.220249				
46.	Total				35,414,848		9,082,831	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

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)	21,045,133			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	23,905			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	880.37			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,007			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,408,013			
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)	4,408,013			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit					
9.	Coronary Care Unit					
10.	PICU	7,742,155	4,559	1,698.21	752	1,277,054
11.	NICU	23,404,320	19,883	1,177.10	6,656	7,834,778
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					9,082,831
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					22,602,676

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

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45) (5A) (5B)		Program Expenses (Col. 4 X Cols. 5A-B) (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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
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.	Pain Management							
23.	Ultrasound							
24.	Cardiac Catheterization							
25.	Anatomic Pathology							
26.	Lab Stem Cell							
27.	Sleep Disorder							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	Psychotherapy							
32.	Implants							
33.	ECT							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* 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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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							
48.	Psych							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

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)		22,602,676	
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)			
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)		1,383,090	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		23,985,766	
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)		35,414,848	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		12,013,401	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. PICU		3,119,840	
H. NICU		26,191,959	
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)		76,740,048	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			52,754,282
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

BHF Page 8

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

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)	23,985,766	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	23,985,766	
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)	23,985,766	

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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)	52,754,282
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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	3,369,358	107,285,589	0.031406	4,253,615		133,589	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	954,448	29,238,029	0.032644	1,183,185		38,624	
5.	Radiology - Diagnostic	741,573	132,338,166	0.005604	3,170,493		17,767	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	160,528	50,770,632	0.003162	4,545,098		14,372	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	202,406	29,078,452	0.006961	699,026		4,866	
17.	EEG	902,102	2,156,952	0.418230	43,844		18,337	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	72,109	6,069,518	0.011881	4,428		53	
21.	Ambulance							
22.	Pain Management							
23.	Ultrasound							
24.	Cardiac Catheterization							
25.	Anatomic Pathology	746,807	15,360,526	0.048619	480,248		23,349	
26.	Lab Stem Cell							
27.	Sleep Disorder							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	Psychotherapy							
32.	Implants							
33.	ECT							
34.	Kidney Acquisition							
35.	Heart Acquisition							
36.	Liver Acquisition							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	165,763	29,537,064	0.005612				
44.	Emergency	790,429	105,060,231	0.007524				
45.	Observation							
46.	Ancillary Total						250,957	

* 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:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	5,405,024	23,905	226.11	5,007		1,132,133	
48.	Psych							
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)						1,132,133	
68.	Ancillary Total (from line 46)						250,957	
69.	Total (Lines 67-68)						1,383,090	

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,415		12,415
Newborn Days			
Total Inpatient Revenue	76,741,995	(1,947)	76,740,048
Ancillary Revenue	35,416,795	(1,947)	35,414,848
Routine Revenue	41,325,200		41,325,200
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. Data came from SSM personnel.

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

Adults & Peds and NICU GME costs from W/S B, Column 25 allocated between St. Mary's and Cardinal Glennon based upon split of days.

Removed \$1,947 in Cardiac Rehab charges as it is non-covered for Illinois Medicaid.

Determined Blood charges on BHF Page 3 to be Anatomic Pathology.

BHF Page 3 charges for Kidney, Heart, and Liver Acquisition come from W/S D-4 series.

Type of Control on BHF Page 1 is "Church" per Medicare report W/S S-2, Line 21.