

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 Medical Center		Medicare Provider Number: 26-0091	
Street: 1465 South Grand Boulevard		Medicaid Provider Number: 19026	
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)) Cardinal Glennon Children's 19026 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)

Title _____ Date _____

Firm _____

Telephone Number _____

Email Address _____

Name (Typewritten)

Title _____

Date _____

Telephone Number _____

Email Address _____

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

Hospital Statement of Cost / Statistical Data

BHF Page 2

PRELIMINARY

Medicare Provider Number: 26-0091				Medicaid Provider Number: 19026			
Program: Medicaid-Hospital				Period Covered by Statement:			
				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	101	36,966		20,450	55.32%		7,722	6.45
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU	36	13,176		4,349	33.01%			
8.	NICU	71	25,986		25,032	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								
22.	Total	208	76,128		49,831	65.46%		7,722	6.45
23.	Observation Bed Days				2,544				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,735			966	8.98
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU				1,543				
8.	NICU				4,392				
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				8,670	17.40%		966	8.98

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: 01/01/2016	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	3,183,432		640,188	
2.	Recovery Room	5,735,199	23,165,356	0.247577	319,150		79,014	
3.	Delivery and Labor Room	5,504,218	41,447,889	0.132799				
4.	Anesthesiology	2,612,771	45,826,861	0.057014	1,235,497		70,441	
5.	Radiology - Diagnostic	16,225,096	90,506,530	0.179270	1,821,835		326,600	
6.	Radiology - Therapeutic	6,952,994	40,955,096	0.169771	224		38	
7.	Nuclear Medicine	1,817,745	5,357,180	0.339310	32,853		11,147	
8.	Laboratory	25,546,006	226,573,070	0.112750	7,626,890		859,932	
9.	Blood							
10.	Blood - Administration	4,583,481	23,092,660	0.198482	911,401		180,897	
11.	Intravenous Therapy	5,965,735	13,619,093	0.438042	37,980		16,637	
12.	Respiratory Therapy	14,068,862	77,211,245	0.182213	6,203,645		1,130,385	
13.	Physical Therapy	1,499,221	11,151,797	0.134438	556,927		74,872	
14.	Occupational Therapy	756,035	6,232,651	0.121302	416,461		50,518	
15.	Speech Pathology	1,438,919	7,258,252	0.198246	323,166		64,066	
16.	EKG	5,832,144	52,658,970	0.110753	490,462		54,320	
17.	EEG	853,999	4,677,349	0.182582	210,601		38,452	
18.	Med. / Surg. Supplies	46,868,375	48,237,497	0.971617	2,640,409		2,565,466	
19.	Drugs Charged to Patients	61,650,957	248,702,713	0.247890	5,193,913		1,287,519	
20.	Renal Dialysis	2,824,838	10,001,224	0.282449	37,056		10,466	
21.	Ambulance							
22.	CT Scan	2,801,106	78,376,209	0.035739	654,809		23,402	
23.	MRI	3,224,129	33,570,528	0.096040	613,216		58,893	
24.	Ultrasound							
25.	Cardiac Catheterizat.	5,653,156	43,532,386	0.129861	125,189		16,257	
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	55,923		11,227	
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	778,105		646,281	
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	69,000		87,290	
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	1,992		1,147	
44.	Emergency	25,300,975	133,246,602	0.189881	2,323,442		441,177	
45.	Observation	7,518,900	40,812,454	0.184231	52,776		9,723	
46.	Total				35,916,354		8,756,355	

* 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: 01/01/2016 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)	19,055,175			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	22,994			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	828.70			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,735			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,266,495			
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)	2,266,495			

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					
9.	Coronary Care Unit					
10.	PICU	10,652,877	4,349	2,449.50	1,543	3,779,579
11.	NICU	23,022,107	25,032	919.71	4,392	4,039,366
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				
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,756,355
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					18,841,795

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: 01/01/2016 To: 12/31/2016

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	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)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	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				
4.	Anesthesiology	3,770,000	45,826,861	0.082266	1,235,497		101,639	
5.	Radiology - Diagnostic	36,631	90,506,530	0.000405	1,821,835		738	
6.	Radiology - Therapeutic	108,893	40,955,096	0.002659	224		1	
7.	Nuclear Medicine							
8.	Laboratory	426,510	226,573,070	0.001882	7,626,890		14,354	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	1,171,775	11,151,797	0.105075	556,927		58,519	
14.	Occupational Therapy	363,334	6,232,651	0.058295	416,461		24,278	
15.	Speech Pathology	237,572	7,258,252	0.032731	323,166		10,578	
16.	EKG	211,703	52,658,970	0.004020	490,462		1,972	
17.	EEG	310,969	4,677,349	0.066484	210,601		14,002	
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	1,992		325	
44.	Emergency	69,710	133,246,602	0.000523	2,323,442		1,215	
45.	Observation							
46.	Ancillary Total						227,621	

* 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: 01/01/2016 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	4,848,498	22,994	210.86	2,735		576,702	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	PICU							
54.	NICU	560,004	25,032	22.37	4,392		98,249	
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)						674,951	
68.	Ancillary Total (from line 46)						227,621	
69.	Total (Lines 67-68)						902,572	

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charge:**

BHF Page 7

PRELIMINARY

Medicare Provider Number: 26-0091		Medicaid Provider Number: 19026	
Program: Medicaid-Hospital		Period Covered by Statement: 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)	18,841,795	
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)	902,572	
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)	2,600,506	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	22,344,873	
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)	35,916,354	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	10,976,774	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. PICU	3,109,738	
	H. NICU	20,591,816	
	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)	70,594,682	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		48,249,809
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: 01/01/2016 To: 12/31/2016

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)	22,344,873	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	22,344,873	
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)	22,344,873	

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:	Medicaid Provider Number:
26-0091	19026
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)	48,249,809
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			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 Charge

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(1)	(2A)	(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: 01/01/2016 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 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:			
26-0091				19026			
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	3,183,432		199,643	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,481,020	45,826,861	0.075960	1,235,497		93,848	
5.	Radiology - Diagnostic	2,610,765	90,506,530	0.028846	1,821,835		52,553	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	435,128	5,357,180	0.081223	32,853		2,668	
8.	Laboratory	1,740,510	226,573,070	0.007682	7,626,890		58,590	
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	490,462		8,105	
17.	EEG	3,481,020	4,677,349	0.744229	210,601		156,735	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	127,615	10,001,224	0.012760	37,056		473	
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	2,323,442		53,112	
45.	Observation							
46.	Ancillary Total						625,727	

* 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		19026	
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	16,602,680	22,994	722.04	2,735		1,974,779	
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)						1,974,779	
68.	Ancillary Total (from line 46)						625,727	
69.	Total (Lines 67-68)						2,600,506	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,670		8,670
Newborn Days			
Total Inpatient Revenue	70,594,682		70,594,682
Ancillary Revenue	35,916,354		35,916,354
Routine Revenue	34,678,328		34,678,328
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.