

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: 01/01/2021	To: 12/31/2021	

Type of Control

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

Type of Hospital

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

Health Care Program

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

☐ 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)) Cardinal Glennon Children's H- 19026 for the cost report beginning 01/01/2021 and ending 12/31/2021 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:		Medicaid Provider Number:	
26-0091		19026	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2021	To: 12/31/2021

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	81	29,565		16,350	55.30%		6,105	7.33
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU	47	15,953		10,456	65.54%			
8.	NICU	65	23,725		17,943	75.63%			
9.	Intermediate Care Unit								
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	193	69,243		44,749	64.63%		6,105	7.33
23.	Observation Bed Days				3,635				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				418			224	7.17
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	PICU				540				
8.	NICU				647				
9.	Intermediate Care Unit								
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				1,605	3.59%		224	7.17

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: 01/01/2021	To: 12/31/2021

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)		(4)	(5)	(6)	(7)
1.	Operating Room	31,781,115	178,579,081	0.177967	1,166,043		207,517	
2.	Recovery Room	4,278,420	22,398,595	0.191013	238,589		45,574	
3.	Delivery and Labor Room	17,760,696	44,200,697	0.401819				
4.	Anesthesiology	4,168,159	57,655,291	0.072294	282,736		20,440	
5.	Radiology - Diagnostic	18,086,863	90,985,875	0.198788	277,480		55,160	
6.	Radiology - Therapeutic	7,338,161	57,603,013	0.127392				
7.	Nuclear Medicine	1,694,796	4,519,334	0.375010	1,900		713	
8.	Laboratory	19,443,442	167,619,977	0.115997	2,003,564		232,407	
9.	Blood							
10.	Blood - Administration	7,865,922	16,072,515	0.489402	140,324		68,675	
11.	Intravenous Therapy	7,762,019	26,847,606	0.289114	26,150		7,560	
12.	Respiratory Therapy	16,232,232	61,204,337	0.265214	1,980,498		525,256	
13.	Physical Therapy	3,671,573	10,216,375	0.359381	90,993		32,701	
14.	Occupational Therapy	1,926,277	6,797,342	0.283387	87,167		24,702	
15.	Speech Pathology	2,054,935	5,957,218	0.344949	39,499		13,625	
16.	EKG	6,686,625	63,746,702	0.104894	199,942		20,973	
17.	EEG	2,843,056	11,121,628	0.255633	143,580		36,704	
18.	Med. / Surg. Supplies	68,563,808	51,924,948	1.320441	319,444		421,807	
19.	Drugs Charged to Patients	59,545,332	360,120,949	0.165348	1,981,628		327,658	
20.	Renal Dialysis	3,774,672	11,518,700	0.327699	5,200		1,704	
21.	Ambulance							
22.	CT Scan	3,534,261	59,945,128	0.058958	102,860		6,064	
23.	MRI	3,548,978	32,571,767	0.108959	46,400		5,056	
24.	Other							
25.	Cardiac Catheterizat.	5,509,564	34,125,530	0.161450	172,500		27,850	
26.	Other							
27.	Cardiac Rehab	833,397	1,063,110	0.783924				
28.	Other							
29.	Endoscopy	6,621,360	26,006,787	0.254601	11,800		3,004	
30.	Clinical Nutrition	2,142,726	732,525	2.925123				
31.	ECT	232,586	624,308	0.372550				
32.	Other							
33.	Impl Dev Chrgd to P.							
34.	Kidney Acquisition	894,126	454,661	1.966577				
35.	Heart Acquisition	31,282	149,292	0.209536				
36.	Liver Acquisition	26,415	74,646	0.353870				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	66,680,449	50,255,489	1.326829	28,885		38,325	
44.	Emergency	30,234,379	154,483,373	0.195713	534,018		104,514	
45.	Observation	10,581,048	27,587,652	0.383543	256,640		98,432	
46.	Total				10,137,840		2,326,421	

* 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: 01/01/2021 To: 12/31/2021

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)	24,459,992			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	19,985			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,223.92			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	418			
3.	Program general inpatient routine cost (Line 1c X Line 2)	511,599			
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)	511,599			

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	16,809,542	10,456	1,607.65	540	868,131
11.	NICU	27,748,575	17,943	1,546.48	647	1,000,573
12.	Intermediate Care Unit					
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)					2,326,421
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,706,724

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: 01/01/2021 To: 12/31/2021

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.	Intermediate Care Unit						
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: 01/01/2021 To: 12/31/2021

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.	CT Scan							
23.	MRI							
24.	Other							
25.	Cardiac Catheterizat.							
26.	Other							
27.	Cardiac Rehab							
28.	Other							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Other							
33.	Impl Dev Chrgd to P.							
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: 01/01/2021 To: 12/31/2021

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.	Intermediate Care Unit							
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: 01/01/2021 To: 12/31/2021

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)		4,706,724	
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)		177,398	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		4,884,122	
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)		10,137,840	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		1,469,400	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. PICU		3,434,929	
H. NICU		4,730,768	
I. Intermediate Care Unit			
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)		19,772,937	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			14,888,815
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: 01/01/2021 To: 12/31/2021

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)	4,884,122	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,884,122	
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)	4,884,122	

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: 01/01/2021 To: 12/31/2021

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)	14,888,815
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 01/01/2021 To: 12/31/2021

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: 01/01/2021 To: 12/31/2021

Line No.	Cost Centers	G M E Cost (CMS 2552-10 W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10 W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	2,335,045	178,579,081	0.013076	1,166,043		15,247	
2.	Recovery Room							
3.	Delivery and Labor Room	3,372,843	44,200,697	0.076307				
4.	Anesthesiology	648,624	57,655,291	0.011250	282,736		3,181	
5.	Radiology - Diagnostic	648,624	90,985,875	0.007129	277,480		1,978	
6.	Radiology - Therapeutic	129,725	57,603,013	0.002252				
7.	Nuclear Medicine	129,725	4,519,334	0.028704	1,900		55	
8.	Laboratory	389,174	167,619,977	0.002322	2,003,564		4,652	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	259,450	63,746,702	0.004070	199,942		814	
17.	EEG	1,167,522	11,121,628	0.104978	143,580		15,073	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Other							
25.	Cardiac Catheterizat.							
26.	Other							
27.	Cardiac Rehab							
28.	Other							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	ECT							
32.	Other							
33.	Impl Dev Chrgd to P.							
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							
44.	Emergency	518,899	154,483,373	0.003359	534,018		1,794	
45.	Observation							
46.	Ancillary Total						42,794	

* 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: 01/01/2021 To: 12/31/2021

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	6,435,533	19,985	322.02	418		134,604	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	PICU							
54.	NICU							
55.	Intermediate Care Unit							
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)						134,604	
68.	Ancillary Total (from line 46)						42,794	
69.	Total (Lines 67-68)						177,398	

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: 01/01/2021 To: 12/31/2021	

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,605		1,605
Newborn Days			
Total Inpatient Revenue	19,772,937		19,772,937
Ancillary Revenue	10,137,840		10,137,840
Routine Revenue	9,635,097		9,635,097
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Hosptial Beds and Bed Days Available adjusted to agree with W/S S-3 or per the attached spreadsheet
 BHF Page 2 - Added the observation days which are allocated between St. Mary's and Cardinal Glennon.
 See Worksheet
 BHF Page 2 - Adjusted the Hospital Discharges to W/S S-3, Col 15. See Worksheet.
 BHF Page 2 - Adjusted the Program discharges so the ave length of stay agree with XIX per the Medicare report
 $(3233 \text{ A\&P} + 912 \text{ ICU} + 632 \text{ PICU} + 1278 \text{ NICU} + 4599 \text{ Int CU per XIX}) / 1483 \text{ XIX discharges} = 7.18 \text{ ave length of stay}$
 $(418 \text{ A\&P} + 540 \text{ PICU} + 647 \text{ NICU per cost report}) / 7.18 \text{ ave length of stay} = 224 \text{ prg discharges}$
 BHF Page 3 - Reclassified Blood to Blood Admin
 BHF Page 3 - Medical Supplies and Implants costs/charges combined on the cost report
 BHF Page 3 - agreed the cost and charges to the as filed Medicare report W/S C columns 1 and 8
 BHF Page 4 - Adults & Peds and NICU costs from W/S C allocated between St. Mary's and Cardinal Glennon based
 upon split of days. See Worksheet
 BHF Page 4 - Agreed the Costs to W/S C, Part I, Col 1
 BHF Page 6a & 6b - Adjusted out the professional fees as none on the ICPR
 BHF Supplemental 2b - Adults & Peds GME costs from W/S B, Part I, Col 25 allocated between St. Mary's and Cardinal
 Glennon based upon split of days. See Worksheet.
 BHF Supplemental 2a & 2b - Included the GME expenses from W/S B, Part I, Col 25