

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: 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: 01/01/2021	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)

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)) St. Mary's Health Center 19035 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:	26-0091	Medicaid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	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	144	52,560		22,540	42.88%		17,051	4.10
2.	Psych	46	16,792		12,280	73.13%		1,570	7.82
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	58	19,281		4,760	24.69%			
6.	Coronary Care Unit								
7.	PICU								
8.	NICU	42	15,330		8,111	52.91%			
9.	Intermediate Care Unit	190	57,578		34,573	60.05%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				5,329				
22.	Total	480	161,541		87,593	54.22%		18,621	4.42
23.	Observation Bed Days				5,010				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				94			110	7.15
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				31				
6.	Coronary Care Unit								
7.	PICU								
8.	NICU				119				
9.	Intermediate Care Unit				543				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				92				
22.	Total				879	1.00%		110	7.15

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		19035	
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	397,320		70,710	
2.	Recovery Room	4,278,420	22,398,595	0.191013	14,399		2,750	
3.	Delivery and Labor Room	17,760,696	44,200,697	0.401819	99,040		39,796	
4.	Anesthesiology	4,168,159	57,655,291	0.072294	90,006		6,507	
5.	Radiology - Diagnostic	18,086,863	90,985,875	0.198788	157,409		31,291	
6.	Radiology - Therapeutic	7,338,161	57,603,013	0.127392	35,880		4,571	
7.	Nuclear Medicine	1,694,796	4,519,334	0.375010				
8.	Laboratory	19,443,442	167,619,977	0.115997	533,943		61,936	
9.	Blood							
10.	Blood - Administration	7,865,922	16,072,515	0.489402	36,679		17,951	
11.	Intravenous Therapy	7,762,019	26,847,606	0.289114	40,020		11,570	
12.	Respiratory Therapy	16,232,232	61,204,337	0.265214	272,792		72,348	
13.	Physical Therapy	3,671,573	10,216,375	0.359381	22,844		8,210	
14.	Occupational Therapy	1,926,277	6,797,342	0.283387	40,309		11,423	
15.	Speech Pathology	2,054,935	5,957,218	0.344949	7,783		2,685	
16.	EKG	6,686,625	63,746,702	0.104894	87,620		9,191	
17.	EEG	2,843,056	11,121,628	0.255633	14,216		3,634	
18.	Med. / Surg. Supplies	68,563,808	51,924,948	1.320441	57,424		75,825	
19.	Drugs Charged to Patients	59,545,332	360,120,949	0.165348	1,079,135		178,433	
20.	Renal Dialysis	3,774,672	11,518,700	0.327699	23,674		7,758	
21.	Ambulance							
22.	CT Scan	3,534,261	59,945,128	0.058958	57,400		3,384	
23.	MRI	3,548,978	32,571,767	0.108959	21,300		2,321	
24.	Other							
25.	Cardiac Catheterizat.	5,509,564	34,125,530	0.161450	8,300		1,340	
26.	Other							
27.	Cardiac Rehab	833,397	1,063,110	0.783924				
28.	Other							
29.	Endoscopy	6,621,360	26,006,787	0.254601	12,400		3,157	
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	4,328		5,743	
44.	Emergency	30,234,379	154,483,373	0.195713	57,510		11,255	
45.	Observation	10,581,048	27,587,652	0.383543	114,033		43,737	
46.	Total				3,285,764		687,526	

* 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: 19035
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)	33,720,381	13,606,519		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	27,550	12,280		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,223.97	1,108.02		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	94			
3.	Program general inpatient routine cost (Line 1c X Line 2)	115,053			
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)	115,053			

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	11,762,148	4,760	2,471.04	31	76,602
9.	Coronary Care Unit					
10.	PICU					
11.	NICU	12,543,538	8,111	1,546.48	119	184,031
12.	Intermediate Care Unit	46,094,534	34,573	1,333.25	543	723,955
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,284,930	5,329	616.43	92	56,712
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					687,526
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,843,879

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:	19035
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:	19035
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:	19035
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: 19035	
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/2021 To: 12/31/2021	
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)	1,843,879	
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)	52,594	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,896,473	
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)	3,285,764	
10.	Inpatient Routine Services (Provider's Records)		
A.	Adults and Pediatrics	191,485	
B.	Psych		
C.	Rehab		
D.	Other (Sub)		
E.	Intensive Care Unit	193,240	
F.	Coronary Care Unit		
G.	PICU		
H.	NICU	1,654,470	
I.	Intermediate Care Unit	435,551	
J.	Other		
K.	Other		
L.	Other		
M.	Other		
N.	Other		
O.	Other		
P.	Other		
Q.	Other		
R.	Other		
S.	Other		
T.	Nursery	101,200	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	5,861,710	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,965,237
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: 19035
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)	1,896,473	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,896,473	
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)	1,896,473	

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	19035
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)	3,965,237
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: 19035
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:	19035
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	397,320		5,195	
2.	Recovery Room							
3.	Delivery and Labor Room	3,372,843	44,200,697	0.076307	99,040		7,557	
4.	Anesthesiology	648,624	57,655,291	0.011250	90,006		1,013	
5.	Radiology - Diagnostic	648,624	90,985,875	0.007129	157,409		1,122	
6.	Radiology - Therapeutic	129,725	57,603,013	0.002252	35,880		81	
7.	Nuclear Medicine	129,725	4,519,334	0.028704				
8.	Laboratory	389,174	167,619,977	0.002322	533,943		1,240	
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	87,620		357	
17.	EEG	1,167,522	11,121,628	0.104978	14,216		1,492	
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	57,510		193	
45.	Observation							
46.	Ancillary Total						18,250	

* 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: 01/01/2021 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	8,871,982	27,550	322.03	94		30,271	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	PICU							
54.	NICU							
55.	Intermediate Care Unit	259,450	34,573	7.50	543		4,073	
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)						34,344	
68.	Ancillary Total (from line 46)						18,250	
69.	Total (Lines 67-68)						52,594	

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
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	787		787
Newborn Days	92		92
Total Inpatient Revenue	5,861,710		5,861,710
Ancillary Revenue	3,285,764		3,285,764
Routine Revenue	2,575,946		2,575,946
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
 $(3233 \text{ A\&P} + 912 \text{ ICU} + 632 \text{ PICU} + 1278 \text{ NICU} + 4599 \text{ Int CU per XIX}) / 1483 \text{ XIX discharges} = 7.18 \text{ ave length of stay}$
 $(94 \text{ A\&P} + 31 \text{ ICU} + 119 \text{ NICU} + 543 \text{ Int CU per cost report}) / 7.18 \text{ ave length of stay} = 110 \text{ prg discharges}$
 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