Hospital Statement of Cost

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

General Information

PRELIMINARY

Name of Hospital: St. Mary's Health Center	**Medicare Provider Number:** 26-0091
Street: 6420 Clayton Road	**Medicaid Provider Number:** 19035
City: St. Louis **State:** Missouri	**Zip:** 63117
Period Covered by Statement: **From:** 01/01/2008	**To:** 12/31/2008

Type of Control

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

Type of Hospital

[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]	Medicaid Hospital	[ ]	Medicaid Sub II	[ ]	DHS - Office of Rehabilitation Services
[ ]	Medicaid Sub I	[ ]	Medicaid Sub III	[ ]	U of I - Division of Specialized Care for Children

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) St. Mary's Health Center 19035 for the cost report beginning 01/01/2008 and ending 12/31/2008 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):	Signed (Officer or Administrator of Provider(s)):
Name (Typewritten)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

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	330	120,780	2,158	71,992	59.61%		18,996	4.17
2.	Psychiatric Unit	44	16,104		9,598	59.60%		1,127	8.52
3.	Rehabilitation Unit	60	21,960		13,373	60.90%		886	15.09
4.	Sub III								
5.	Intensive Care Unit	12	4,392		3,497	79.62%			
6.	Coronary Care Unit	12	4,392		3,672	83.61%			
7.	Other								
8.	Other								
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	48	17,568		4,191	23.85%			
22.	**Total**	**506**	**185,196**	**2,158**	**106,323**	**57.41%**		**21,009**	**4.86**
23.	Observation Bed Days				6,190				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics			977	3,923			573	6.96
2.	Psychiatric Unit								
3.	Rehabilitation Unit								
4.	Sub III								
5.	Intensive Care Unit				13				
6.	Coronary Care Unit				50				
7.	Other								
8.	Other								
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				204				
22.	**Total**			**977**	**4,190**	**3.94%**		**573**	**6.96**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	31,393,073	86,266,419	0.363908	219,869		80,012	
2.	Recovery Room	2,922,110	10,042,965	0.290961	21,581		6,279	
3.	Delivery and Labor Room	5,172,039	28,991,652	0.178398	330,772		59,009	
4.	Anesthesiology	2,461,260	26,317,347	0.093522	179,642		16,800	
5.	Radiology - Diagnostic	15,636,061	108,435,785	0.144197	222,076		32,023	
6.	Radiology - Therapeutic	2,448,117	10,598,628	0.230984				
7.	Nuclear Medicine	2,330,472	10,677,315	0.218264	1,615		352	
8.	Laboratory	19,601,096	123,915,551	0.158181	1,067,778		168,902	
9.	Anatomic Pathology	2,617,584	9,841,113	0.265985	96,563		25,684	
10.	Blood - Administration	5,613,614	14,945,218	0.375613	228,564		85,852	
11.	Intravenous Therapy	1,181,865	1,103,165	1.071340	3,749		4,016	
12.	Respiratory Therapy	8,620,193	41,899,974	0.205733	772,541		158,937	
13.	Physical Therapy	3,460,376	8,957,694	0.386302	6,323		2,443	
14.	Occupational Therapy	2,302,351	7,010,326	0.328423	2,686		882	
15.	Speech Pathology	2,121,290	5,807,250	0.365283	6,049		2,210	
16.	EKG	3,118,085	17,502,640	0.178149	17,893		3,188	
17.	EEG	882,097	2,198,805	0.401171				
18.	Med. / Surg. Supplies	40,995,390	73,293,747	0.559330				
19.	Drugs Charged to Patients	18,536,932	75,367,867	0.245953	508,340		125,028	
20.	Renal Dialysis	2,100,676	6,503,802	0.322992	12,038		3,888	
21.	Ambulance							
22.	Ultrasound	1,513,870	10,901,285	0.138871	54,045		7,505	
23.	Lab Stem Cell	344,862	89,652	3.846674				
24.	Pharmacy IV	12,910,633	37,071,203	0.348266	641,164		223,296	
25.	Sleep Disorder	674,993	3,858,810	0.174923				
26.	Pain Management	678,635	2,124,447	0.319441	1,720		549	
27.	Cardiac Cath Lab	4,316,143	27,532,491	0.156765	42,863		6,719	
28.	Vascular Lab	1,213,007	13,842,335	0.087630	120,159		10,530	
29.	Endoscopy	4,723,817	18,543,452	0.254743	32,211		8,206	
30.	Clinical Nutrition	1,103,500	226,353	4.875129	159		775	
31.	Psychotherapy	1,933,090	8,507,701	0.227216				
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	15,011,489	15,142,255	0.991364	273		271	
44.	Emergency	19,220,021	79,532,156	0.241664	42,384		10,243	
45.	Observation	7,064,097	12,512,235	0.564575				
46.	**Total**				**4,633,057**		**1,043,599**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	64,778,449	6,254,579	5,539,955	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	78,182	9,598	13,373	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	828.56	651.65	414.26	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,923			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,250,441			
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)	977			
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)	3,250,441			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	4,863,723	3,497	1,390.83	13	18,081
9.	Coronary Care Unit	5,461,623	3,672	1,487.37	50	74,369
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	468,740	4,191	111.86	204	22,819
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,043,599
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**4,409,309**

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: 01/01/2008 To: 12/31/2008

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

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

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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.	Anatomic Pathology							
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.	Ultrasound							
23.	Lab Stem Cell							
24.	Pharmacy IV							
25.	Sleep Disorder							
26.	Pain Management							
27.	Cardiac Cath Lab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	Psychotherapy							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
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

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Psychiatric Unit							
49.	Rehabilitation Unit							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
54.	Other							
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

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	4,409,309	
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)	704,864	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**5,114,173**	
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)	4,633,057	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	9,354,160	
	B. Psychiatric Unit		
	C. Rehabilitation Unit		
	D. Sub III		
	E. Intensive Care Unit	42,948	
	F. Coronary Care Unit	165,677	
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	235,462	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	14,431,304	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		9,317,131
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	5,114,173	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,114,173	
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, Sec. 115.2 (B)		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**5,114,173**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	**Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 08

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	9,317,131
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: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	General Service	Sub I Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
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 Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
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 Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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: 01/01/2008 To: 12/31/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	2,442,053	86,266,419	0.028308	219,869		6,224	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	1,289,584	26,317,347	0.049001	179,642		8,803	
5.	Radiology - Diagnostic	761,948	108,435,785	0.007027	222,076		1,561	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	678,637	123,915,551	0.005477	1,067,778		5,848	
9.	Anatomic Pathology							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,885	41,899,974	0.000331	772,541		256	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	145,794	17,502,640	0.008330	17,893		149	
17.	EEG	836,581	2,198,805	0.380471				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	61,207	6,503,802	0.009411	12,038		113	
21.	Ambulance							
22.	Ultrasound							
23.	Lab Stem Cell							
24.	Pharmacy IV							
25.	Sleep Disorder							
26.	Pain Management							
27.	Cardiac Cath Lab							
28.	Vascular Lab							
29.	Endoscopy							
30.	Clinical Nutrition							
31.	Psychotherapy							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	130,173	15,142,255	0.008597	273		2	
44.	Emergency	29,506	79,532,156	0.000371	42,384		16	
45.	Observation							
46.	**Ancillary Total**						**22,972**	

* 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: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2008 To: 12/31/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	13,526,531	78,182	173.01	3,923		678,718	
48.	Psychiatric Unit	166,622	9,598	17.36				
49.	Rehabilitation Unit							
50.	Sub III							
51.	Intensive Care Unit	853,938	3,497	244.19	13		3,174	
52.	Coronary Care Unit							
53.	Other							
54.	Other							
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)**						**681,892**	
68.	**Ancillary Total (from line 46)**						**22,972**	
69.	**Total (Lines 67-68)**						**704,864**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
26-0091	19035
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2008 To: 12/31/2008

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,986		3,986
Newborn Days	204		204
Total Inpatient Revenue	14,431,304		14,431,304
Ancillary Revenue	4,633,057		4,633,057
Routine Revenue	9,798,247		9,798,247
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Determined Blood Administration charges to be Anatomic Pathology.
Determined Blood charges to be Blood Administration.
Determined Nursery Bed Days using prior year amounts.
Adults & Peds split between St. Mary's and Cardinal Glennon.
Nursery split between St. Mary's and Cardinal Glennon based upon prior year.