

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. Louis Children's Hospital		Medicare Provider Number: 26-3301	
Street: One Children's Place		Medicaid Provider Number: 19018	
City: St. Louis	State: Missouri	Zip: 63110	
Period Covered by Statement:	From: 01/01/2020	To: 12/31/2020	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ XXXX XXXX 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	☐
☐ 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. Louis Children's Hospital 19018 for the cost report beginning 01/01/2020 and ending 12/31/2020 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

Name (Typewritten)

Title

Firm

Telephone Number

Email Address

Name (Typewritten)

Title

Date

Telephone Number

Email Address

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

Hospital Statement of Cost / Statistical Data

BHF Page 2

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	200	73,200		44,775	61.17%		9,775	9.68
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	80	29,280		8,929	30.50%			
6.	Coronary Care Unit								
7.	NICU	122	44,652		40,900	91.60%			
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								
22.	Total	402	147,132		94,604	64.30%		9,775	9.68
23.	Observation Bed Days				4,440				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,422			300	14.40
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				707				
6.	Coronary Care Unit								
7.	NICU				2,192				
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								
22.	Total				4,321	4.57%		300	14.40

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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	38,530,873	135,521,692	0.284315	1,787,735		508,280	
2.	Recovery Room	14,370,724	24,743,132	0.580796	121,293		70,446	
3.	Delivery and Labor Room							
4.	Anesthesiology	3,173,822	39,836,350	0.079672	440,283		35,078	
5.	Radiology - Diagnostic	9,909,633	44,682,012	0.221781	560,539		124,317	
6.	Radiology - Therapeutic	2,110,887	6,861,898	0.307624	28,621		8,805	
7.	Nuclear Medicine							
8.	Laboratory	24,560,707	110,934,379	0.221399	2,011,953		445,444	
9.	Blood							
10.	Blood - Administration	6,171,392	23,273,124	0.265172	331,125		87,805	
11.	Intravenous Therapy							
12.	Respiratory Therapy	12,398,808	57,264,747	0.216517	3,192,431		691,216	
13.	Physical Therapy	11,887,084	18,133,734	0.655523	270,892		177,576	
14.	Occupational Therapy	3,682,989	8,047,906	0.457633	240,221		109,933	
15.	Speech Pathology	6,701,001	13,203,173	0.507530	116,271		59,011	
16.	EKG	4,684,404	9,586,699	0.488636	364,188		177,955	
17.	EEG	2,244,958	16,890,858	0.132910	379,202		50,400	
18.	Med. / Surg. Supplies	18,622,404	41,330,942	0.450568	519,003		233,846	
19.	Drugs Charged to Patients	72,681,287	194,685,973	0.373326	2,343,023		874,711	
20.	Renal Dialysis	2,596,368	2,202,986	1.178568	264,560		311,802	
21.	Ambulance	8,905,820	13,460,288	0.661637				
22.	CT Scan	1,145,697	12,603,354	0.090904	149,231		13,566	
23.	MRI	1,942,199	54,338,287	0.035743	477,325		17,061	
24.	Cardiac Cath	3,111,901	28,880,706	0.107750	15,211		1,639	
25.	Implantable Devices	16,485,520	40,935,315	0.402721	837,348		337,218	
26.	Home Dialysis	535,062	2,786,877	0.191993				
27.	Kidney Acquisition	487,059	459,230	1.060599				
28.	Liver Acquisition	1,748,078	2,070,915	0.844109				
29.	Heart Acquisition	2,145,562	2,120,112	1.012004				
30.	Lung Acquisition	1,901,706	1,974,240	0.963260				
31.	Other Organ Acquisit	2,340,793	4,801,141	0.487549				
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	20,448,900	33,945,303	0.602407	106,414		64,105	
44.	Emergency	21,220,683	69,874,148	0.303699	439,148		133,369	
45.	Observation	9,512,300	13,827,954	0.687904	70,147		48,254	
46.	Total				15,066,164		4,581,837	

* 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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	105,438,767			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	49,215			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,142.41			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,422			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,046,507			
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)	3,046,507			

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	35,590,683	8,929	3,985.97	707	2,818,081
9.	Coronary Care Unit					
10.	NICU	89,960,702	40,900	2,199.53	2,192	4,821,370
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					4,581,837
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					15,267,795

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

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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.	NICU						
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 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	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
26-3301		19018	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2020	To: 12/31/2020

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	267,307	135,521,692	0.001972	1,787,735		3,525	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	5,047,154	39,836,350	0.126697	440,283		55,783	
5.	Radiology - Diagnostic	34,187	44,682,012	0.000765	560,539		429	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	822,783	110,934,379	0.007417	2,011,953		14,923	
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	564,822	13,460,288	0.041962				
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Heart Acquisition							
30.	Lung Acquisition							
31.	Other Organ Acquisit							
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	427,715	33,945,303	0.012600	106,414		1,341	
44.	Emergency	313,003	69,874,148	0.004480	439,148		1,967	
45.	Observation							
46.	Ancillary Total						77,968	

* 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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	1,802,676	49,215	36.63	1,422		52,088	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	127,498	40,900	3.12	2,192		6,839	
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)						58,927	
68.	Ancillary Total (from line 46)						77,968	
69.	Total (Lines 67-68)						136,895	

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

BHF Page 7

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	15,267,795	
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)	136,895	
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)	2,933,706	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	18,338,396	
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)	15,066,164	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,498,291	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	6,029,990	
	F. Coronary Care Unit		
	G. NICU	9,149,189	
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	34,743,634	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		16,405,238
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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	18,338,396	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	18,338,396	
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)	18,338,396	

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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)	16,405,238
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: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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

	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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	9,418,350	135,521,692	0.069497	1,787,735		124,242	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,536,420	39,836,350	0.164082	440,283		72,243	
5.	Radiology - Diagnostic	977,797	44,682,012	0.021883	560,539		12,266	
6.	Radiology - Therapeutic	2,343,879	6,861,898	0.341579	28,621		9,776	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,122,325	57,264,747	0.019599	3,192,431		62,568	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology	1,487,497	13,203,173	0.112662	116,271		13,099	
16.	EKG							
17.	EEG	793,209	16,890,858	0.046961	379,202		17,808	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	977,797	12,603,354	0.077582	149,231		11,578	
23.	MRI	977,797	54,338,287	0.017995	477,325		8,589	
24.	Cardiac Cath	312,784	28,880,706	0.010830	15,211		165	
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Heart Acquisition							
30.	Lung Acquisition							
31.	Other Organ Acquisit							
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	29,404,804	33,945,303	0.866241	106,414		92,180	
44.	Emergency	17,562,450	69,874,148	0.251344	439,148		110,377	
45.	Observation							
46.	Ancillary Total						534,891	

* 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:	26-3301	Medicaid Provider Number:	19018
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	18,929,764	49,215	384.63	1,422		546,944	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	10,325,270	8,929	1,156.37	707		817,554	
52.	Coronary Care Unit							
53.	NICU	19,299,250	40,900	471.86	2,192		1,034,317	
54.	Other							
55.	Other			#VALUE!				
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)						2,398,815	
68.	Ancillary Total (from line 46)						534,891	
69.	Total (Lines 67-68)						2,933,706	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,321		4,321
Newborn Days			
Total Inpatient Revenue	34,743,634		34,743,634
Ancillary Revenue	15,066,164		15,066,164
Routine Revenue	19,677,470		19,677,470
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Added Observation Bed Days per W/S S-3

BHF Page 3 - Reclassified Blood to Blood Administration

BHF Page 6 - no Professional fees per IPCR; professional fees reported on 2019 cost report so allowed on 2020 rept.

BHF Page 4 - added the observation bed days to line 1b.

BHF Page 6b - added the observation bed days to line 47, col 2.

BHF Page 8 - did not include the O/P program charges on this report.

BHF Supplemental No 2 - added the observation bed days to line 47 col 2