

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: DePaul Hospital St. Louis	Medicare Provider Number: 26-0104	
Street: 12303 DePaul Drive	Medicaid Provider Number: 19024	
City: Bridgeton	State: Missouri	Zip: 63044
Period Covered by Statement:	From: 01/01/2020	To: 12/31/2020

Type of Control

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

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)) DePaul Hospital St. Louis 19024 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:	26-0104	Medicaid Provider Number:	19024
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	350	128,100		77,645	60.61%		20,229	4.66
2.	Psych	25	9,150		4,544	49.66%		856	5.31
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	70	25,620		16,643	64.96%			
6.	Coronary Care Unit								
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				1,965				
22.	Total	445	162,870		100,797	61.89%		21,085	4.69
23.	Observation Bed Days				8,536				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				171			34	5.79
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				26				
6.	Coronary Care Unit								
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				3				
22.	Total				200	0.20%		34	5.79

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:	26-0104	Medicaid Provider Number:	19024
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	25,444,414	112,493,005	0.226187	137,133		31,018	
2.	Recovery Room	1,720,697	9,408,238	0.182893	7,006		1,281	
3.	Delivery and Labor Room	6,312,282	10,429,426	0.605238	14,388		8,708	
4.	Anesthesiology	1,027,942	29,213,256	0.035188	23,751		836	
5.	Radiology - Diagnostic	11,449,328	65,047,675	0.176014	23,603		4,154	
6.	Radiology - Therapeutic	6,044,133	45,254,442	0.133559				
7.	Nuclear Medicine	1,248,960	6,271,829	0.199138	3,920		781	
8.	Laboratory	8,043,514	93,186,059	0.086317	95,486		8,242	
9.	Blood							
10.	Blood - Administration	4,142,174	9,242,088	0.448186	6,102		2,735	
11.	Intravenous Therapy	4,567,631	21,467,361	0.212771				
12.	Respiratory Therapy	6,603,795	33,783,982	0.195471	25,503		4,985	
13.	Physical Therapy	3,451,552	7,861,081	0.439068	16,115		7,076	
14.	Occupational Therapy	1,804,354	4,574,895	0.394403	12,785		5,042	
15.	Speech Pathology	730,933	3,019,988	0.242032	14,355		3,474	
16.	EKG	6,483,749	67,238,297	0.096429	51,364		4,953	
17.	EEG	434,435	6,682,009	0.065016	3,038		198	
18.	Med. / Surg. Supplies	32,423,915	24,569,849	1.319663	49,228		64,964	
19.	Drugs Charged to Patients	65,720,666	329,891,873	0.199219	71,484		14,241	
20.	Renal Dialysis	2,702,117	6,809,522	0.396814	9,702		3,850	
21.	Ambulance							
22.	CT Scan	2,957,117	65,361,691	0.045242	63,171		2,858	
23.	MRI	845,190	15,519,881	0.054459	23,792		1,296	
24.	Cardiac Catheterization	3,633,947	42,562,668	0.085379	35,682		3,046	
25.	Implantables	21,306,885	29,671,199	0.718100	14,701		10,557	
26.	Electroshock Therapy	249,153	426,047	0.584802				
27.	Endoscopy	2,148,072	13,381,523	0.160525	5,000		803	
28.	Cardiac Rehab	1,146,169	773,835	1.481154				
29.	Radioisotope							
30.	Perinatal Clinic	2,259,841	5,687,332	0.397346				
31.	Clinical Nutrition	885,638	49,117	18.031191				
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	12,672,273	23,935,574	0.529433	316		167	
44.	Emergency	21,869,248	112,060,072	0.195156	38,395		7,493	
45.	Observation	7,967,673	26,334,077	0.302561	2,936		888	
46.	Total				748,956		193,646	

* 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: 26-0104	Medicaid Provider Number: 19024
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)	80,424,008	7,172,665		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	86,181	4,544		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	933.20	1,578.49		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	171			
3.	Program general inpatient routine cost (Line 1c X Line 2)	159,577			
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)	159,577			

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	26,362,907	16,643	1,584.02	26	41,185
9.	Coronary Care Unit					
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	1,745,476	1,965	888.28	3	2,665
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					193,646
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					397,073

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

Preliminary

Medicare Provider Number:	26-0104	Medicaid Provider Number:	19024
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.	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 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:	26-0104	Medicaid Provider Number:	19024
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 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	28,643	112,493,005	0.000255	137,133		35	
2.	Recovery Room							
3.	Delivery and Labor Room	1,472	10,429,426	0.000141	14,388		2	
4.	Anesthesiology	3,552,965	29,213,256	0.121622	23,751		2,889	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	303,523	93,186,059	0.003257	95,486		311	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	19,005	21,467,361	0.000885				
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	359,859	67,238,297	0.005352	51,364		275	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,814	6,809,522	0.000266	9,702		3	
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catheterization							
25.	Implantables							
26.	Electroshock Therapy							
27.	Endoscopy							
28.	Cardiac Rehab							
29.	Radioisotope							
30.	Perinatal Clinic	442,652	5,687,332	0.077831				
31.	Clinical Nutrition							
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	809,613	23,935,574	0.033825	316		11	
44.	Emergency	4,087,335	112,060,072	0.036474	38,395		1,400	
45.	Observation							
46.	Ancillary Total						4,926	

* 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:	26-0104	Medicaid Provider Number:	19024
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	7,939,052	86,181	92.12	171		15,753	
48.	Psych	421,660	4,544	92.79				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,790,808	16,643	107.60	26		2,798	
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)						18,551	
68.	Ancillary Total (from line 46)						4,926	
69.	Total (Lines 67-68)						23,477	

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

BHF Page 7

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
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)	397,073	
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)	23,477	
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)	3,317	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	423,867	
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)	748,956	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	295,076	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	66,459	
	F. Coronary Care Unit		
	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	3,378	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	1,113,869	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		690,002
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: 26-0104	Medicaid Provider Number: 19024
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)	423,867	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	423,867	
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)	423,867	

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:	26-0104	Medicaid Provider Number:	19024
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)	690,002
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: 26-0104	Medicaid Provider Number: 19024
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:	26-0104	Medicaid Provider Number:	19024
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	1,211,631	112,493,005	0.010771	137,133		1,477	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	9,441	29,213,256	0.000323	23,751		8	
5.	Radiology - Diagnostic	14,161	65,047,675	0.000218	23,603		5	
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.	Cardiac Catheterization	7,868	42,562,668	0.000185	35,682		7	
25.	Implantables							
26.	Electroshock Therapy							
27.	Endoscopy							
28.	Cardiac Rehab							
29.	Radioisotope							
30.	Perinatal Clinic							
31.	Clinical Nutrition							
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							
44.	Emergency	89,692	112,060,072	0.000800	38,395		31	
45.	Observation							
46.	Ancillary Total						1,528	

* 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:	26-0104	Medicaid Provider Number:	19024
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	901,643	86,181	10.46	171		1,789	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
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)						1,789	
68.	Ancillary Total (from line 46)						1,528	
69.	Total (Lines 67-68)						3,317	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
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	197		197
Newborn Days	3		3
Total Inpatient Revenue	1,113,869		1,113,869
Ancillary Revenue	748,956		748,956
Routine Revenue	364,913		364,913
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Per SSM - The Medicare report incorrectly reported non-distinct psych days under distinct psych subprovider.

This in turn grossly understated the psych per diem and overstated the A&P per diem.

SSM DePaul is not HFS certified for psych (cos 21).

While the filed psych report will be accepted at this time, the final report will most likely eliminate the psych report when an updated IPCR is run.

BHF Page 7 - psych routine has been calculated $(7172665/4544) \times 30$ based on Medicare average.

BHF Page 2 - removed the SNF beds and bed day information

BHF Page 2 - added the Psych I/P Hospital days and removed Labor & Delivery days from col 4, Part I Hospital

BHF Page 2 - changed the hospital discharge days to agree with the Medicare report

BHF Page 2 - removed the L & D Program days from line 20 Part II Program

BHF Page 2 - changed the program discharge days to 34 so the length of stay agrees with XVIII report

BHF Page 3 - reclassified blood to blood admin

BHF Page 4 - removed the SNF and L&D items

BHF Page 6 - no prof fees on IPCR; prof fees reported on Medicare report and 2019 report, so allowed in 2020