

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

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 01/01/2021 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

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: 01/01/2021 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	235	85,775		50,260	58.60%		10,958	9.51
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	60	21,900		10,614	48.47%			
6.	Coronary Care Unit								
7.	NICU	122	44,530		43,363	97.38%			
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	417	152,205		104,237	68.48%		10,958	9.51
23.	Observation Bed Days				4,963				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				937			200	13.37
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				223				
6.	Coronary Care Unit								
7.	NICU				1,513				
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				2,673	2.56%		200	13.37

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

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	43,541,845	156,536,875	0.278157	1,443,850		401,617	
2.	Recovery Room	16,716,235	30,363,631	0.550535	69,652		38,346	
3.	Delivery and Labor Room							
4.	Anesthesiology	3,561,473	48,161,021	0.073949	266,330		19,695	
5.	Radiology - Diagnostic	10,172,446	54,474,948	0.186736	459,191		85,747	
6.	Radiology - Therapeutic	2,704,634	8,931,284	0.302827	45,527		13,787	
7.	Nuclear Medicine							
8.	Laboratory	26,618,022	132,282,493	0.201221	1,206,804		242,834	
9.	Blood							
10.	Blood - Administration	6,945,382	27,427,044	0.253231	184,505		46,722	
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,611,239	71,669,277	0.203870	2,705,384		551,547	
13.	Physical Therapy	13,874,677	21,256,638	0.652722	150,576		98,284	
14.	Occupational Therapy	4,407,893	9,947,126	0.443132	143,369		63,531	
15.	Speech Pathology	8,528,292	18,356,932	0.464582	95,155		44,207	
16.	EKG	5,083,289	10,457,637	0.486084	215,932		104,961	
17.	EEG	2,238,412	18,368,323	0.121863	201,435		24,547	
18.	Med. / Surg. Supplies	19,575,527	44,136,452	0.443523	322,131		142,873	
19.	Drugs Charged to Patients	78,539,066	206,060,647	0.381145	1,362,381		519,265	
20.	Renal Dialysis	2,224,766	2,090,945	1.064000				
21.	Ambulance	10,033,030	17,389,931	0.576945				
22.	CT Scan	1,001,543	15,283,745	0.065530	139,927		9,169	
23.	MRI	2,352,616	66,039,184	0.035625	307,046		10,939	
24.	Cardiac Cath	2,764,452	27,771,442	0.099543	13,624		1,356	
25.	Implantable Devices	15,404,540	36,559,395	0.421357	193,739		81,633	
26.	Home Dialysis	530,003	2,397,008	0.221110				
27.	Kidney Acquisition	902,824	831,867	1.085298	18,886		20,497	
28.	Liver Acquisition	2,154,613	1,888,433	1.140953				
29.	Heart Acquisition	2,076,275	2,629,122	0.789722				
30.	Lung Acquisition	962,755	928,140	1.037295				
31.	Other Organ Acquisit							
32.	CAR-T Cell Therapy	2,123,330	3,596,268	0.590426				
33.	Allogeneic Stem Cell Acq	2,176,566	1,517,876	1.433955				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	21,579,486	42,256,523	0.510678	9,948		5,080	
44.	Emergency	25,268,345	94,067,354	0.268620	367,961		98,842	
45.	Observation	10,850,508	16,663,122	0.651169	58,194		37,894	
46.	Total				9,981,547		2,663,373	

* 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: 01/01/2021 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)	120,732,863			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	55,223			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,186.28			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	937			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,048,544			
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)	2,048,544			

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	40,653,258	10,614	3,830.15	223	854,123
9.	Coronary Care Unit					
10.	NICU	100,272,769	43,363	2,312.40	1,513	3,498,661
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)					2,663,373
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					9,064,701

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: 01/01/2021 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.	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: 01/01/2021	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.	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.	CAR-T Cell Therapy							
33.	Allogeneic Stem Cell Acq							
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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	26-3301	Medicaid Provider Number:	19018
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.	NICU							
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**

BHF Page 7

Preliminary

Medicare Provider Number: 26-3301	Medicaid Provider Number: 19018
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)	9,064,701	
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)	1,871,054	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	10,935,755	
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)	9,981,547	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,135,165	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,069,820	
	F. Coronary Care Unit		
	G. NICU	7,862,603	
	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)	23,049,135	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		12,113,380
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: 01/01/2021 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)	10,935,755	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	10,935,755	
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)	10,935,755	

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: 01/01/2021 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)	12,113,380
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: 01/01/2021 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

	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:		Medicaid Provider Number:	
26-3301		19018	
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 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	11,888,420	156,536,875	0.075946	1,443,850		109,655	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	7,075,663	48,161,021	0.146917	266,330		39,128	
5.	Radiology - Diagnostic	1,504,025	54,474,948	0.027609	459,191		12,678	
6.	Radiology - Therapeutic	2,723,546	8,931,284	0.304945	45,527		13,883	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,265,042	71,669,277	0.031604	2,705,384		85,501	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology	1,346,510	18,356,932	0.073352	95,155		6,980	
16.	EKG							
17.	EEG	1,054,679	18,368,323	0.057418	201,435		11,566	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	51,589	2,090,945	0.024673				
21.	Ambulance							
22.	CT Scan	1,304,994	15,283,745	0.085384	139,927		11,948	
23.	MRI	1,304,994	66,039,184	0.019761	307,046		6,068	
24.	Cardiac Cath	665,165	27,771,442	0.023951	13,624		326	
25.	Implantable Devices							
26.	Home Dialysis							
27.	Kidney Acquisition							
28.	Liver Acquisition							
29.	Heart Acquisition							
30.	Lung Acquisition							
31.	Other Organ Acquisit							
32.	CAR-T Cell Therapy							
33.	Allogeneic Stem Cell Acq							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,774,562	42,256,523	0.089325	9,948		889	
44.	Emergency	18,934,778	94,067,354	0.201290	367,961		74,067	
45.	Observation							
46.	Ancillary Total						372,689	

* 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: 01/01/2021 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	29,262,396	55,223	529.90	937		496,516	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	11,836,221	10,614	1,115.15	223		248,678	
52.	Coronary Care Unit							
53.	NICU	21,585,977	43,363	497.80	1,513		753,171	
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)						1,498,365	
68.	Ancillary Total (from line 46)						372,689	
69.	Total (Lines 67-68)						1,871,054	

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,673		2,673
Newborn Days			
Total Inpatient Revenue	23,049,134	1	23,049,135
Ancillary Revenue	9,981,546	1	9,981,547
Routine Revenue	13,067,588		13,067,588
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 of the Medicare report
 BHF Page 2 - Program discharges are higher than hospital discharges; left as filed since NICU % is greater than hospital
 BHF Page 3 - Reclassified Blood to Blood Administration
 BHF Page 3 - I/P Kidney Acquisition charges are 23% of the total I/P hospital charges. The program occupancy percentage is 2.56%. Allowed 2.56% of the I/P hospital kidney acquisition charges on that line and reclassified the remaining balance to I/P OR charges.
 $\$737,743 \text{ I/P Hospital Kid Acq (W/S C, Part I, Col 1)} * 2.56\% = \$18,886 \text{ allowable I/P prog Kidney Acq charges}$
 $\$165,530 \text{ per as filed I/P Kid Acq} - \$18,886 \text{ allowed} = \$150,644 \text{ reclassified to OR}$
 BHF Page 4 - added the observation bed days to line 1b.
 BHF Page 6a & 6b - Adjusted out the professional fees as none on the IPCR
 BHF Supplemental No 2 - added the observation bed days to line 47 col 2
 Minor rounding adjustment