

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: Mount Sinai Childrens		Medicare Provider Number: 14-0018	
Street: 15th St and California Ave		Medicaid Provider Number: 3006	
City: Chicago	State: Illinois	Zip: 60608	
Period Covered by Statement:	From: 07/01/2020	To: 06/30/2021	

Type of Control

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

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) XXXX Childrens

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

☒ Medicaid Hospital XXXX	☐ 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)) Mount Sinai Childrens 3006 for the cost report beginning 07/01/2020 and ending 06/30/2021 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Name (Typewritten)

Title	Date
Firm	
Telephone Number	
Email Address	

Name (Typewritten)

Title
Date
Telephone Number
Email Address

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

Hospital Statement of Cost / Statistical Data

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	1	365		231	63.29%		684	5.55
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	1	365		195	53.42%			
6.	Coronary Care Unit								
7.	NICU	25	9,125		3,368	36.91%			
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	16	6,000		1,696	28.27%			
22.	Total	43	15,855		5,490	34.63%		684	5.55
23.	Observation Bed Days								

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				103			22	6.14
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				31				
6.	Coronary Care Unit								
7.	NICU				1				
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				311				
22.	Total				446	8.12%		22	6.14

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

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0018		3006	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 07/01/2020	To: 06/30/2021

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10 W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10 W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)		(4)	(5)	(6)	(7)
1.	Operating Room	17,697,242	100,440,073	0.176197	175,423		30,909	
2.	Recovery Room	2,326,474	31,889,074	0.072955	25,226		1,840	
3.	Delivery and Labor Room	6,789,514	31,642,948	0.214566	6,857		1,471	
4.	Anesthesiology	1,469,996	42,077,832	0.034935	129,549		4,526	
5.	Radiology - Diagnostic	11,069,425	72,146,255	0.153430	67,361		10,335	
6.	Radiology - Therapeutic	1,880,281	9,300,211	0.202176				
7.	Nuclear Medicine	668,247	3,710,978	0.180073				
8.	Laboratory	21,378,846	161,674,628	0.132234	242,440		32,059	
9.	Blood							
10.	Blood - Administration	2,875,547	9,859,928	0.291640	8,017		2,338	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,282,057	31,063,118	0.105658	541,685		57,233	
13.	Physical Therapy	948,244	2,906,049	0.326300	5,299		1,729	
14.	Occupational Therapy	877,618	2,953,099	0.297185	4,010		1,192	
15.	Speech Pathology	359,937	1,733,246	0.207666	24,752		5,140	
16.	EKG	2,249,702	29,012,639	0.077542	54,143		4,198	
17.	EEG	875,811	2,164,592	0.404608	1,948		788	
18.	Med. / Surg. Supplies	19,147,009	41,826,535	0.457772	301,892		138,198	
19.	Drugs Charged to Patients	19,932,609	109,783,736	0.181562	261,051		47,397	
20.	Renal Dialysis	4,531,189	21,194,113	0.213795				
21.	Ambulance							
22.	MRI	907,838	12,052,439	0.075324				
23.	O/P Chemotherapy	2,313,739	6,487,018	0.356672				
24.	Ear, Nose, Throat							
25.	Pulmonary Function	513,086	14,030,091	0.036570				
26.	Under The Rainbow							
27.	CT Scan	2,875,479	80,511,391	0.035715	94,464		3,374	
28.	Cardiac Catheterization	1,542,466	18,066,506	0.085377				
29.	SPASTICITY CLINIC	148,420	344,982	0.430225				
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic	1,138,330	7,355,133	0.154767				
32.	MSH Spec@Schwab	1,739,770	4,592,009	0.378869				
33.	MSH OP Behavioral Health	3,030,446	4,327,850	0.700220				
34.	Under The Rainbow	1,673,751	2,798,538	0.598080				
35.	Implants	9,855,980	34,014,354	0.289759				
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	17,099,768	143,341,503	0.119294				
45.	Observation	5,813,128	11,454,047	0.507517				
46.	Total				1,944,117		342,727	

* 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: 14-0018	Medicaid Provider Number: 3006
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	258,038			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	231			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,117.05			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	103			
3.	Program general inpatient routine cost (Line 1c X Line 2)	115,056			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	115,056			

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	559,564	195	2,869.56	31	88,956
9.	Coronary Care Unit					
10.	NICU	3,690,793	3,368	1,095.84	1	1,096
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	997,906	1,696	588.39	311	182,989
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					342,727
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					730,824

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

PRELIMINARY

Medicare Provider Number:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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.	MRI							
23.	O/P Chemotherapy							
24.	Ear, Nose, Throat							
25.	Pulmonary Function							
26.	Under The Rainbow							
27.	CT Scan							
28.	Cardiac Catherization							
29.	SPASTICITY CLINIC							
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic							
32.	MSH Spec@Schwab							
33.	MSH OP Behavioral Health							
34.	Under The Rainbow							
35.	Implants							
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:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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: 14-0018	Medicaid Provider Number: 3006
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		730,824	
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)		15,151	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		745,975	
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	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		1,944,117	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		495,418	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		154,643	
F. Coronary Care Unit			
G. NICU		751,965	
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		341,878	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		3,688,021	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			2,942,046
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: 14-0018	Medicaid Provider Number: 3006
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	745,975	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	745,975	
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)	745,975	

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0018	3006
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2020 To: 06/30/2021

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)	2,942,046
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	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: 14-0018	Medicaid Provider Number: 3006
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(A)	General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B)	Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C)	Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
(A)	Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B)	Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	876,033	100,440,073	0.008722	175,423		1,530	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	71,907	42,077,832	0.001709	129,549		221	
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	89,691	29,012,639	0.003091	54,143		167	
17.	EEG	99,742	2,164,592	0.046079	1,948		90	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	MRI							
23.	O/P Chemotherapy							
24.	Ear, Nose, Throat							
25.	Pulmonary Function							
26.	Under The Rainbow							
27.	CT Scan							
28.	Cardiac Catheterization							
29.	SPASTICITY CLINIC							
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic							
32.	MSH Spec@Schwab							
33.	MSH OP Behavioral Health							
34.	Under The Rainbow							
35.	Implants							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	387,372	143,341,503	0.002702				
45.	Observation							
46.	Ancillary Total						2,008	

* 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:	14-0018	Medicaid Provider Number:	3006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	23,577	231	102.06	103		10,512	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	16,147	195	82.81	31		2,567	
52.	Coronary Care Unit							
53.	NICU	215,722	3,368	64.05	1		64	
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)						13,143	
68.	Ancillary Total (from line 46)						2,008	
69.	Total (Lines 67-68)						15,151	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3006
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,561	(1,426)	135
Newborn Days	669	(358)	311
Total Inpatient Revenue	18,817,514	(15,129,493)	3,688,021
Ancillary Revenue	9,603,658	(7,659,541)	1,944,117
Routine Revenue	9,213,856	(7,469,952)	1,743,904
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - According to the IPCR for the Adult's and Children's report, both reports have A&P, ICU and Nursery
So, reclassified 1 bed from the A&P and ICU from the Adult's report to the Children's report; Reclassified 365 bed
days available from A&P and ICU from the Adult's to Children's report as well. Since the A&P has 63.3% occupancy
reclassified (365*63.3%) 231 I/P A&P days from Adult to Children. Since the ICU has 53.55% occupancy,
reclassified (365*53.55%) 195 I/P ICU days from Adult to Children.
BHF Page 2 - Part II Nursery days allocated between Adult and Children based upon the as-filed nursery days
reported on the cost report.
BHF Page 2 - Part I Nursery I/P days, Bed days available and total beds allocated between the Adult's and Children's
reports; see attached spreadsheet for calculation
BHF Page 2 - Allocated the number of hospital discharges between the Adult and Children's reports as follows:
(41,823 A&P+2,932 ICU+4,146 CCU Adult report) / 52,498 total I/P days less nurs * 9,470 total discharges = 8,786
(231 A&P+195 ICU+3,368 Child report) / 52,498 total I/P days less nurs * 9,470 total discharges = 684 child discharges
BHF Page 2 - The child's report seems to be greatly overstated per the IPCR; so, adjusted the program days to agree
with the IPCR then subtracted those days from the total on W/S S-3 of the Medicare report to arrive at the program
days reported on the Adult report. See attached spreadsheet
BHF Page 2 - Allocated the number of program discharges from W/S S-3 between the Adult and Children's reports
(6,629 A&P + 398 ICU + 179 CCU Adult) / 7341 total I/P pgm days * 1172 pgm discharges = 1150 adult dschg
(103 A&P + 31 ICU + 1 NICU Child) / 7341 total I/P pgm days * 1172 pgm discharges = 22 Child dschg
BHF Page 3 - Adjusted the costs & charges in cols 1 & 2 to agree with W/S C, Part I, Cols 1 & 8 of the Medicare rpt
BHF Page 3 - Reclassified the Blood costs/charges to Blood Admin Costs/Charges
BHF Page 3 - Adjusted the I/P charges to agree with the IPCR
BHF Page 3 - Other Charges on the IPCR are reported under I/P Recovery Room
BHF Page 4 - Routine costs for A&P, ICU and Nursery allocated between Mt Sinai and Sinai Children's hospitals;
see attached spreadsheet
BHF Page 6a & 6b - Adjusted out the professional fees as none on the IPCR
BHF Page 7 - Agreed the Routine charges to the IPCR
BHF Supplemental 2a & 2b - GME Expenses for A&P and ICU allocated between Mt Sinai and Sinai Children's; see
attached spreadsheet