

Hospital Statement of Cost

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

General Information Preliminary

Name of Hospital: 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: 01/01/2019	To: 12/31/2019	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/>

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 01/01/2019 and ending 12/31/2019 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

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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	353	128,845		82,122	63.74%		22,947	4.25
2.	Psych	26	9,490		6,037	63.61%		1,179	5.12
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	56	20,440		15,447	75.57%			
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				2,227				
22.	Total	435	158,775		105,833	66.66%		24,126	4.29
23.	Observation Bed Days				11,811				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				150			81	2.44
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				48				
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				8				
22.	Total				206	0.19%		81	2.44

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

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

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	27,983,115	139,084,638	0.201195	152,926		30,768	
2.	Recovery Room	1,994,956	12,563,752	0.158787	7,789		1,237	
3.	Delivery and Labor Room	675,641	13,424,525	0.050329	23,791		1,197	
4.	Anesthesiology	992,060	36,823,385	0.026941	21,546		580	
5.	Radiology - Diagnostic	12,824,669	79,258,298	0.161809	32,401		5,243	
6.	Radiology - Therapeutic	6,293,135	46,610,610	0.135015				
7.	Nuclear Medicine							
8.	Laboratory	6,920,868	92,260,063	0.075015	158,992		11,927	
9.	Blood							
10.	Blood - Administration	4,301,281	11,328,155	0.379698	2,425		921	
11.	Intravenous Therapy	4,740,111	18,407,965	0.257503				
12.	Respiratory Therapy	6,519,128	29,398,768	0.221748	24,468		5,426	
13.	Physical Therapy	3,549,257	7,600,711	0.466964	15,722		7,342	
14.	Occupational Therapy	1,583,383	3,931,209	0.402773	11,087		4,466	
15.	Speech Pathology	623,015	2,721,256	0.228944	14,594		3,341	
16.	EKG	6,990,064	77,909,578	0.089720	69,019		6,192	
17.	EEG	653,860	7,977,603	0.081962	38,460		3,152	
18.	Med. / Surg. Supplies	37,040,104	24,909,275	1.487000	83,823		124,645	
19.	Drugs Charged to Patients	64,174,412	330,030,791	0.194450	153,364		29,822	
20.	Renal Dialysis	2,445,799	6,317,815	0.387127				
21.	Ambulance							
22.	CT Scan	3,066,776	75,846,545	0.040434	80,763		3,266	
23.	MRI	959,976	19,346,006	0.049621	23,400		1,161	
24.	Cardiac Catheterization	3,888,512	50,716,645	0.076671	97,696		7,490	
25.	Implantables	26,719,009	40,321,964	0.662642	26,524		17,576	
26.	Electroshock Therapy	317,375	948,158	0.334728				
27.	Endoscopy	2,533,551	17,150,266	0.147727	1,886		279	
28.	Cardiac Rehab	1,235,444	915,800	1.349033				
29.	Radioisotope	1,769,532	8,859,353	0.199736	6,001		1,199	
30.	Perinatal Clinic	2,430,177	6,385,213	0.380595				
31.	Clinical Nutrition	1,252,223	169,374	7.393242				
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	15,148,568	26,675,933	0.567874	477		271	
44.	Emergency	20,892,046	110,240,992	0.189513	66,643		12,630	
45.	Observation	14,474,499	36,913,325	0.392121	16,344		6,409	
46.	Total				1,130,141		286,540	

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

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	88,534,650	4,069,527		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	93,933	6,037		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	942.53	674.10		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	150			
3.	Program general inpatient routine cost (Line 1c X Line 2)	141,380			
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)	141,380			

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	19,244,973	15,447	1,245.87	48	59,802
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	3,973,631	2,227	1,784.30	8	14,274
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					286,540
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					501,996

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: 01/01/2019 To: 12/31/2019

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)	
						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

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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	20,986	139,084,638	0.000151	152,926		23	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,090,656	36,823,385	0.083932	21,546		1,808	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	256,417	92,260,063	0.002779	158,992		442	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	22,715	18,407,965	0.001234				
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	384,893	77,909,578	0.004940	69,019		341	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,353	6,317,815	0.000214				
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	461,273	6,385,213	0.072241				
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	1,101,840	26,675,933	0.041305	477		20	
44.	Emergency	2,094,169	110,240,992	0.018996	66,643		1,266	
45.	Observation							
46.	Ancillary Total						3,900	

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

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

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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	7,727,843	93,933	82.27	150		12,341	
48.	Psych	976,278	6,037	161.72				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,779,630	15,447	115.21	48		5,530	
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)						17,871	
68.	Ancillary Total (from line 46)						3,900	
69.	Total (Lines 67-68)						21,771	

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

Preliminary

Medicare Provider Number: 26-0104		Medicaid Provider Number: 19024	
Program: Medicaid - Hospital		Period Covered by Statement: From: 01/01/2019 To: 12/31/2019	
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)	501,996	
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)	21,771	
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)	3,075	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	526,842	
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)	1,130,141	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	525,133	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	138,131	
	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	9,008	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	1,802,413	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,275,571
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	526,842	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	526,842	
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)	526,842	

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

Preliminary

Medicare Provider Number: 26-0104	Medicaid Provider Number: 19024
Program: Medicaid - Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	1,275,571
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) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 01/01/2019 To: 12/31/2019

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: 01/01/2019 To: 12/31/2019

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	574,334	139,084,638	0.004129	152,926		631	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	11,817	36,823,385	0.000321	21,546		7	
5.	Radiology - Diagnostic	37,816	79,258,298	0.000477	32,401		15	
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	18,908	50,716,645	0.000373	97,696		36	
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	56,725	110,240,992	0.000515	66,643		34	
45.	Observation							
46.	Ancillary Total						723	

* 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: 01/01/2019 To: 12/31/2019

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	1,472,467	93,933	15.68	150		2,352	
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)						2,352	
68.	Ancillary Total (from line 46)						723	
69.	Total (Lines 67-68)						3,075	

**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: 01/01/2019 To: 12/31/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	198		198
Newborn Days	8		8
Total Inpatient Revenue	1,802,413		1,802,413
Ancillary Revenue	1,130,141		1,130,141
Routine Revenue	672,272		672,272
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. See email and adjusted filed.

SSM DePaul is not HFS certified for psych (cos 21). IPCR only shows psych days under acute as they were billed as part of an acute stay. 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.

SSM claims no ancillary or routine for psych. This is most likely due to IPCR including such amount under the acute data. At this time, psych routine has been calculated (7786032/6037)x137 based on Medicare average. No ancillary has been calculated as SSM claims there are no ancillary charges.