

Hospital Statement of Cost

Illinois Department of Public Aid, Office of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Barnes-Jewish Hospital		Medicare Provider Number: 26-0032	
Street: One Barnes-Jewish Hospital Plaza		Public Aid Provider Number: 19014	
City: St. Louis	State: Missouri	Zip: 63110	
Period Covered by Statement:	From: 01/01/06	To: 12/31/06	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input 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) XXXX XXXX	<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	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

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)) Barnes-Jewish Hospital 19014 for the cost report beginning 01/01/06 and ending 12/31/06 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 _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Public Aid Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	1,145	414,932	18,952	242,167	58.36%		52,240	5.31	
2.	Psychiatric Unit	61	22,265	489	15,875	71.30%		1,691	9.39	
3.										
4.										
5.	Intensive Care Unit	29	10,585		9,563	90.34%				
6.	Coronary Care Unit	15	5,475		4,449	81.26%				
7.	Surgical ICU	24	8,760		7,501	85.63%				
8.	Neuro ICU	20	7,300		5,978	81.89%				
9.	Cardiothoracic ICU	29	10,585		7,592	71.72%				
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	24	8,760		8,021	91.56%				
16.	Total	1,347	488,662	19,441	301,146	61.63%		53,931	5.44	
17.	Observation Bed Days				914					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				8,462			1,598	5.99	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				379					
6.	Coronary Care Unit				73					
7.	Surgical ICU				245					
8.	Neuro ICU				169					
9.	Cardiothoracic ICU				251					
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				217					
16.	Total				9,796	3.25%		1,598	5.99	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

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

PRELIMINARY

Medicare Provider Number:	26-0032	Public Aid Provider Number:	19014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/06 To: 12/31/06

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.442511	5,759,348			2,548,575		
2.	Recovery Room	0.402738	414,879			167,088		
3.	Delivery and Labor Room	0.445659	978,847			436,232		
4.	Anesthesiology	0.345707	723,188			250,011		
5.	Radiology - Diagnostic	0.245966	3,062,922			753,375		
6.	Radiology - Therapeutic	0.264637	297,759			78,798		
7.	Radioisotope	0.232721	128,496			29,904		
8.	Laboratory	0.129589	7,894,988			1,023,104		
9.	Blood							
10.	Blood - Administration	0.244452	3,757,414			918,507		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.185375	2,304,130			427,128		
13.	Physical Therapy	0.407653	254,497			103,746		
14.	Occupational Therapy	0.320846	188,568			60,501		
15.	Speech Pathology	0.432087	48,720			21,051		
16.	EKG	0.105143	834,528			87,745		
17.	EEG	0.339709	192,311			65,330		
18.	Med. / Surg. Supplies	0.441573	1,960,447			865,680		
19.	Drugs Charged to Patients	0.272438	10,173,650			2,771,689		
20.	Renal Dialysis	0.256549	332,537			85,312		
21.	Ambulance							
22.	HLA Lab	0.215576	38,841			8,373		
23.	CT Scan	0.055155	1,796,706			99,097		
23.01	Ultrasound	0.142301	216,993			30,878		
23.02	Cardiac Catheterization Laboratory	0.356133	1,415,717			504,184		
23.03	Endoscopy	0.294693	334,026			98,435		
23.04	Electroshock Therapy	0.538092						
23.05	O/P Psych	0.485521						
23.06	Kidney Transplant	0.553377	57,500			31,819		
23.07	Liver Transplant	0.664199	331,200			219,983		
23.08	Heart Transplant	0.660890	110,000			72,698		
23.09	Other Organ Acquisition	1.222716	84,381			103,174		
Outpatient Service Cost Centers								
24.	Clinic	1.947091	19,381			37,737		
25.	Emergency	0.455310	713,633			324,924		
26.	Observation Beds (Non-distinct Par	0.980878						
27.	Total		44,425,607			12,225,078		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 863.66	\$ 772.55	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	8,462			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 7,308,291	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$ 12.06	\$	\$
5.	Medically necessary private room days applicable to the program (OHF 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)	\$ 7,308,291	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,066.64	379	\$ 783,257
9.	Coronary Care Unit	\$ 1,197.65	73	\$ 87,428
10.	Surgical ICU	\$ 1,508.62	245	\$ 369,612
11.	Neuro ICU	\$ 1,291.88	169	\$ 218,328
12.	Cardiothoracic ICU	\$ 1,435.12	251	\$ 360,215
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 252.79	217	\$ 54,855
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 12,225,078
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 21,407,064

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

Medicare Provider Number: 26-0032		Public Aid Provider Number: 19014	
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/06 To: 12/31/06	

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF 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.	Psychiatric Unit						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Neuro ICU						
10.	Cardiothoracic ICU						
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

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

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
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.	Radioisotope									
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.	HLA Lab									
23.	CT Scan									
23.01	Ultrasound									
23.02	Cardiac Catheterization Laboratory									
23.03	Endoscopy									
23.04	Electroshock Therapy									
23.05	O/P Psych									
23.06	Kidney Transplant									
23.07	Liver Transplant									
23.08	Heart Transplant									
23.09	Other Organ Acquisition									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Surgical ICU									
34.	Neuro ICU									
35.	Cardiothoracic ICU									
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	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
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 26-0032		Public Aid Provider Number: 19014		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/06 To: 12/31/06		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	21,407,064		
3.	Interns and Residents Not in an Approved Teaching Program (OHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (OHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	21,407,064		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	44,425,607
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	6,153,562
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	654,834
	F. Coronary Care Unit	122,678
	G. Surgical ICU	438,555
	H. Neuro ICU	295,764
	I. Cardiothoracic ICU	448,600
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	87,668
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	52,627,268
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	31,220,204
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	21,407,064		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	21,407,064		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF Page 9, Part III, Line 4, Cols. 2B, 3B, & 4B)			
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With HCFA Pub. 15-II, Sec. 115.2 (B)			
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	21,407,064		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (OHF Page 7, Line 12)	31,220,204
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 (OHF Page 7, Line 13)					
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		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
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**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psychiatric Unit	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I Psychiatric Unit	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)		10,296,246		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)		9,974,291		
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)		321,955		
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)		15,386		
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)		489		
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)		658.39		
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)		648.27		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)		10.12		
6. Private room cost differential (To OHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) Divided by (Line 1A Above))		12.06		
7. Private room cost differential adjustment (Line 2B X Line 6)		5,897		
8. General inpatient routine service cost (net of swing bed and private room) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)		12,264,206		
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to OHF Page 4, Line 1)		772.55		

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to OHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	164,497,756	371,736,965	0.442511
2.	Recovery Room	16,639,838	41,316,733	0.402738
3.	Delivery and Labor Room	10,403,589	23,344,271	0.445659
4.	Anesthesiology	15,631,987	45,217,436	0.345707
5.	Radiology - Diagnostic	56,101,131	228,085,336	0.245966
6.	Radiology - Therapeutic	22,308,386	84,297,984	0.264637
7.	Radioisotope	4,403,916	18,923,591	0.232721
8.	Laboratory	47,108,554	363,523,568	0.129589
9.	Blood			
10.	Blood - Administration	28,043,678	114,720,665	0.244452
11.	Intravenous Therapy			
12.	Respiratory Therapy	12,853,614	69,338,340	0.185375
13.	Physical Therapy	5,609,403	13,760,250	0.407653
14.	Occupational Therapy	1,978,971	6,167,985	0.320846
15.	Speech Pathology	661,176	1,530,191	0.432087
16.	EKG	7,093,748	67,467,459	0.105143
17.	EEG	1,390,591	4,093,477	0.339709
18.	Med. / Surg. Supplies	25,930,093	58,722,099	0.441573
19.	Drugs Charged to Patients	92,058,024	337,904,078	0.272438
20.	Renal Dialysis	3,253,796	12,682,935	0.256549
21.	Ambulance			
22.	HLA Lab	2,369,756	10,992,651	0.215576
23.	CT Scan	7,666,311	138,995,772	0.055155
23.01	Ultrasound	2,704,902	19,008,274	0.142301
23.02	Cardiac Catheterization Laboratory	38,548,928	108,243,191	0.356133
23.03	Endoscopy	8,770,549	29,761,677	0.294693
23.04	Electroshock Therapy	550,493	1,023,046	0.538092
23.05	O/P Psych	1,948,708	4,013,640	0.485521
23.06	Kidney Transplant	6,088,231	11,001,952	0.553377
23.07	Liver Transplant	5,023,939	7,563,911	0.664199
23.08	Heart Transplant	1,451,374	2,196,090	0.660890
23.09	Other Organ Acquisition	3,209,248	2,624,689	1.222716
Outpatient Ancillary Centers				
24.	Clinic	32,716,484	16,802,748	1.947091
25.	Emergency	37,159,331	81,613,168	0.455310
26.	Observation Beds (Non-distinct Part)	710,383	724,232	0.980878
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	209,939,541	243,081	863.66
28.	Psychiatric Unit			See Supplement 1
29.				
30.				
31.	Intensive Care Unit	19,763,309	9,563	2,066.64
32.	Coronary Care Unit	5,328,325	4,449	1,197.65
33.	Surgical ICU	11,316,176	7,501	1,508.62
34.	Neuro ICU	7,722,865	5,978	1,291.88
35.	Cardiothoracic ICU	10,895,454	7,592	1,435.12
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,027,652	8,021	252.79

