

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: Cardinal Glennon Children's Hospital		Medicare Provider Number: 26-0091	
Street: 1465 South Grand Boulevard		Medicaid Provider Number: 19026	
City: St. Louis	State: Missouri	Zip: 63104	
Period Covered by Statement:	From: 01/01/2006	To: 12/31/2006	

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 checked="" type="checkbox"/> Corporation XXXX XXXX	<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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) XXXX XXXX Children's Hospital

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital XXXX XXXX	<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)) Cardinal Glennon Children's f 19026 for the cost report beginning 01/01/2006 and ending 12/31/2006 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 Healthcare and Family Services 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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

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	101	36,865		23,429	63.55%		5,006	7.24	
2.										
3.										
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Pediatric ICU	19	6,935		4,557	65.71%				
8.	Neonatal ICU	68	24,820		8,277	33.35%				
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	21	7,765		7,899	101.73%				
16.	Total	209	76,385		44,162	57.82%		5,006	7.24	
17.	Observation Bed Days				1,732					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				3,922			1,274	5.37	
2.										
3.										
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Pediatric ICU				950					
8.	Neonatal ICU				1,973					
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				3,492					
16.	Total				10,337	23.41%		1,274	5.37	

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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room	0.415588	4,372,646			1,817,219		
2.	Recovery Room	0.286227	163,285			46,737		
3.	Delivery and Labor Room	0.295058						
4.	Anesthesiology	0.156849	796,904			124,994		
5.	Radiology - Diagnostic	0.173667	2,382,432			413,750		
6.	Radiology - Therapeutic	0.230287	50,319			11,588		
7.	Nuclear Medicine	0.229355	6,778			1,555		
8.	Laboratory	0.170375	5,271,488			898,130		
9.	Anatomic Pathology	0.268154	165,794			44,458		
10.	Blood - Administration	0.384454	724,941			278,706		
11.	Intravenous Therapy	0.910889						
12.	Respiratory Therapy	0.139125	6,086,649			846,805		
13.	Physical Therapy	0.461534	86,773			40,049		
14.	Occupational Therapy	0.322013	97,610			31,432		
15.	Speech Pathology	0.446514	4,920			2,197		
16.	EKG	0.148113	789,420			116,923		
17.	EEG	1.102108	166,318			183,300		
18.	Med. / Surg. Supplies	49.379299	632			31,208		
19.	Drugs Charged to Patients	0.240956	6,387,680			1,539,150		
20.	Renal Dialysis	0.283750	269			76		
21.	Ambulance							
22.	Ultrasound	0.167015	276,390			46,161		
23.	Pain Management	0.131840						
23.01	Cardiac Catheterization	0.301592	117,395			35,405		
23.02	Vascular Lab	0.087377						
23.03	Endoscopy	0.215943						
23.04	Pharmacy-Intravenous DrugsThera	0.275764						
23.05	Sleep Disorder	0.283219	14,043			3,977		
23.06	Psychotherapy	0.220821						
23.07	Clinical Nutrition	4.281407						
23.08	Lab Stem Cell	2.818121						
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic	0.908589	30,735			27,925		
25.	Emergency	0.309948						
26.	Observation	0.670419						
27.	Total		27,993,421			6,541,745		

* 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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 857.07	\$	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,922			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 3,361,429	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$	\$	\$
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)	\$ 3,361,429	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$		\$
10.	Pediatric ICU	\$ 1,698.17	950	\$ 1,613,262
11.	Neonatal ICU	\$ 1,601.17	1,973	\$ 3,159,108
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 678.34	3,492	\$ 2,368,763
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 6,541,745
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 17,044,307

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

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

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 (BHF Page 2, Part I, Col. 4)	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.							
4.							
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Pediatric ICU						
9.	Neonatal ICU						
10.	Other						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
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										
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:	26-0091	Medicaid Provider Number:	19026
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2006 To: 12/31/2006

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 (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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	221,754	122,002,992	0.001818	4,372,646			7,949		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	4,115,199	26,089,546	0.157734	796,904			125,699		
5.	Radiology - Diagnostic	1,427,823	103,509,102	0.013794	2,382,432			32,863		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	391,121	9,803,828	0.039895	6,778			270		
8.	Laboratory									
9.	Anatomic Pathology	713,065	9,276,406	0.076869	165,794			12,744		
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	13,052	63,544,519	0.000205	6,086,649			1,248		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	293,600	17,232,994	0.017037	789,420			13,449		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Pain Management									
23.01	Cardiac Catheterization	53,518	52,288,525	0.001024	117,395			120		
23.02	Vascular Lab									
23.03	Endoscopy	20,750	20,355,659	0.001019						
23.04	Pharmacy-Intravenous DrugsTherap									
23.05	Sleep Disorder									
23.06	Psychotherapy	84,000	7,514,547	0.011178						
23.07	Clinical Nutrition									
23.08	Lab Stem Cell									
23.09	Other									
Outpatient Ancillary Cost Centers										
24.	Clinic	212,705	12,985,266	0.016380	30,735			503		
25.	Emergency	3,468,243	58,270,583	0.059520						
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	13,681	25,161	0.54	3,922			2,118		
28.										
29.										
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Pediatric ICU									
34.	Neonatal ICU	166,965	8,277	20.17	1,973			39,795		
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery	4,099	7,899	0.52	3,492			1,816		
37.	Total							238,574		

* 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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	17,044,307		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)	238,574		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	17,282,881		
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)	27,993,421
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	7,907,223
	B.	
	C.	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Pediatric ICU	3,483,576
	H. Neonatal ICU	6,738,134
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	9,188,937
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	55,311,291
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	38,028,410
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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	17,282,881		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	17,282,881		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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)	17,282,881		

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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

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 (BHF Page 7, Line 12)	38,028,410
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)		
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 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)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
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: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

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

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

BHF Supplement No. 2

Preliminary

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026		
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006	To:	12/31/2006

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 BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	50,703,015	122,002,992	0.415588
2.	Recovery Room	2,528,880	8,835,212	0.286227
3.	Delivery and Labor Room	8,770,691	29,725,337	0.295058
4.	Anesthesiology	4,092,123	26,089,546	0.156849
5.	Radiology - Diagnostic	17,976,124	103,509,102	0.173667
6.	Radiology - Therapeutic	1,534,308	6,662,582	0.230287
7.	Nuclear Medicine	2,248,554	9,803,828	0.229355
8.	Laboratory	18,655,062	109,493,985	0.170375
9.	Anatomic Pathology	2,487,502	9,276,406	0.268154
10.	Blood - Administration	5,634,982	14,657,105	0.384454
11.	Intravenous Therapy	1,171,708	1,286,334	0.910889
12.	Respiratory Therapy	8,840,648	63,544,519	0.139125
13.	Physical Therapy	2,188,757	4,742,353	0.461534
14.	Occupational Therapy	642,315	1,994,687	0.322013
15.	Speech Pathology	970,571	2,173,664	0.446514
16.	EKG	2,552,431	17,232,994	0.148113
17.	EEG	1,999,047	1,813,839	1.102108
18.	Med. / Surg. Supplies	155,051	3,140	49.379299
19.	Drugs Charged to Patients	16,561,089	68,730,679	0.240956
20.	Renal Dialysis	2,213,140	7,799,599	0.283750
21.	Ambulance			
22.	Ultrasound	1,442,867	8,639,130	0.167015
23.	Pain Management	803,579	6,095,096	0.131840
23.01	Cardiac Catheterization	15,769,778	52,288,525	0.301592
23.02	Vascular Lab	1,131,209	12,946,358	0.087377
23.03	Endoscopy	4,395,659	20,355,659	0.215943
23.04	Pharmacy-Intravenous DrugsTherapy	11,524,811	41,792,337	0.275764
23.05	Sleep Disorder	429,139	1,515,220	0.283219
23.06	Psychotherapy	1,659,373	7,514,547	0.220821
23.07	Clinical Nutrition	1,061,181	247,858	4.281407
23.08	Lab Stem Cell	213,591	75,792	2.818121
23.09	Other			
Outpatient Ancillary Centers				
24.	Clinic	11,798,271	12,985,266	0.908589
25.	Emergency	18,060,851	58,270,583	0.309948
26.	Observation	4,994,609	7,449,976	0.670419
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	21,564,847	25,161	857.07
28.				
29.				
30.	Sub III			
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Pediatric ICU	7,738,577	4,557	1,698.17
34.	Neonatal ICU	13,252,905	8,277	1,601.17
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	5,358,175	7,899	678.34

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19026
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2006 To: 12/31/2006

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	6,845		6,845
Newborn Days	3,492		3,492
Total Inpatient Revenue	55,311,291		55,311,291
Ancillary Revenue	27,993,421		27,993,421
Routine Revenue	27,317,870		27,317,870
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

Determined Blood Administration charges to be Anatomic Pathology.

Determined Blood charges to be Blood Administration.

Determined Nursery Bed Days using prior year amounts.

Adults & Peds need to be split between St. Mary's Adults & Peds, St. Mary's Rehab, and Cardinal Glennon. Professional Component also spread.

Nursery split between St. Mary's and Cardinal Glennon based upon prior year. Professional Component also spread.