

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: St. Mary's Health Center		Medicare Provider Number: 26-0091	
Street: 6420 Clayton Road		Medicaid Provider Number: 19035	
City: St. Louis	State: Missouri	Zip: 63117	
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 checked="" type="checkbox"/> General Short-Term XXXX XXXX	<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 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)) St. Mary's Health Center 19035 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: 19035
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	312	113,855		69,248	60.82%		22,962	3.33	
2.	Psychiatric Unit	37	13,573		9,605	70.77%		1,160	8.28	
3.	Rehabilitation Unit	3	1,098		483	43.99%		30	16.10	
4.	Sub III									
5.	Intensive Care Unit	12	4,377		3,485	79.62%				
6.	Coronary Care Unit	12	4,380		3,797	86.69%				
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	48	17,520		15,223	86.89%				
16.	Total	424	154,803		101,841	65.79%		24,152	3.59	
17.	Observation Bed Days				5,118					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,298			574	2.38	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				31					
6.	Coronary Care Unit				38					
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				3,232					
16.	Total				4,599	4.52%		574	2.38	

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: 19035
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)	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	0.415588	293,599			122,016		
2.	Recovery Room	0.286227	19,351			5,539		
3.	Delivery and Labor Room	0.295058	2,527,157			745,658		
4.	Anesthesiology	0.156849	157,381			24,685		
5.	Radiology - Diagnostic	0.173667	244,289			42,425		
6.	Radiology - Therapeutic	0.230287	7,477			1,722		
7.	Nuclear Medicine	0.229355	21,256			4,875		
8.	Laboratory	0.170375	1,104,073			188,106		
9.	Anatomic Pathology	0.268154	89,895			24,106		
10.	Blood - Administration	0.384454	255,247			98,131		
11.	Intravenous Therapy	0.910889	6,325			5,761		
12.	Respiratory Therapy	0.139125	1,309,470			182,180		
13.	Physical Therapy	0.461534						
14.	Occupational Therapy	0.322013						
15.	Speech Pathology	0.446514						
16.	EKG	0.148113	17,320			2,565		
17.	EEG	1.102108						
18.	Med. / Surg. Supplies	49.379299						
19.	Drugs Charged to Patients	0.240956	503,279			121,268		
20.	Renal Dialysis	0.283750	38,862			11,027		
21.	Ambulance							
22.	Ultrasound	0.167015	55,875			9,332		
23.	Pain Management	0.131840						
23.01	Cardiac Catheterization	0.301592	346,515			104,506		
23.02	Vascular Lab	0.087377	123,785			10,816		
23.03	Endoscopy	0.215943	16,034			3,462		
23.04	Pharmacy-Intravenous DrugsThera	0.275764	872,714			240,663		
23.05	Sleep Disorder	0.283219						
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	158			144		
25.	Emergency	0.309948						
26.	Observation	0.670419						
27.	Total		8,010,062			1,948,987		

* 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: 19035
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 Psychiatric Unit	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 857.07	\$ 505.97	\$ 857.07	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,298			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,112,477	\$	\$	\$
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)	\$ 1,112,477	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,719.22	31	\$ 53,296
9.	Coronary Care Unit	\$ 1,463.29	38	\$ 55,605
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 678.34	3,232	\$ 2,192,395
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 1,948,987
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 5,362,760

**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: 19035
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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
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:	19035
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	293,599			534		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	4,115,199	26,089,546	0.157734	157,381			24,824		
5.	Radiology - Diagnostic	1,427,823	103,509,102	0.013794	244,289			3,370		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	391,121	9,803,828	0.039895	21,256			848		
8.	Laboratory									
9.	Anatomic Pathology	713,065	9,276,406	0.076869	89,895			6,910		
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	13,052	63,544,519	0.000205	1,309,470			268		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	293,600	17,232,994	0.017037	17,320			295		
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	346,515			355		
23.02	Vascular Lab									
23.03	Endoscopy	20,750	20,355,659	0.001019	16,034			16		
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	158			3		
25.	Emergency	3,468,243	58,270,583	0.059520						
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	40,439	74,366	0.54	1,298			701		
28.	Psychiatric Unit	24,150	9,605	2.51						
29.	Rehabilitation Unit	263	483	0.54						
30.	Sub III									
31.	Intensive Care Unit	44,183	3,485	12.68	31			393		
32.	Coronary Care Unit	44,136	3,797	11.62	38			442		
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery	7,901	15,223	0.52	3,232			1,681		
37.	Total							40,640		

* 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: 19035
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)	5,362,760		
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)	40,640		
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)	5,403,400		
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)	8,010,062
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,045,092
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	99,069
	F. Coronary Care Unit	119,562
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	4,966,068
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	15,239,853
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	9,836,453
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: 19035
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)	5,403,400		
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)	5,403,400		
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)	5,403,400		

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: 19035
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)	9,836,453
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: 19035
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 Psychiatric Unit	Sub II Rehabilitation Unit	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 Psychiatric Unit	Sub II Rehabilitation Unit	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 Psychiatric Unit	Sub II Rehabilitation Unit	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: 19035	
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	63,737,192	74,366	857.07
28.	Psychiatric Unit	4,859,816	9,605	505.97
29.	Rehabilitation Unit	413,967	483	857.07
30.	Sub III			
31.	Intensive Care Unit	5,991,480	3,485	1,719.22
32.	Coronary Care Unit	5,556,110	3,797	1,463.29
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	10,326,307	15,223	678.34

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

Preliminary

Medicare Provider Number: 26-0091	Medicaid Provider Number: 19035
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	1,367		1,367
Newborn Days	3,232		3,232
Total Inpatient Revenue	15,239,853		15,239,853
Ancillary Revenue	8,010,062		8,010,062
Routine Revenue	7,229,791		7,229,791
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.

Rehab data is included. On Final most likely Rehab data for Medicaid will come directly from IPCR.