

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: Christian Hospital Northeast		Medicare Provider Number: 26-0180	
Street: 11133 Dunn Road		Medicaid Provider Number: 9993	
City: St. Louis	State: Missouri	Zip: 63136	
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 501(c)(3)	<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)) Christian Hospital Northeast 9993 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 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: 26-0180	Medicaid Provider Number: 9993
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 Occu-pancy (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	345	125,925		67,756	53.81%		13,699	5.76	
2.	Rehabilitation Unit	18	6,570		4,595	69.94%		372	12.35	
3.	Psychiatric Unit	20	7,300		4,146	56.79%		437	9.49	
4.	Sub III									
5.	Intensive Care Unit	26	9,490		6,360	67.02%				
6.	Coronary Care Unit	27	9,855		4,747	48.17%				
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total	436	159,140		87,604	55.05%		14,508	6.04	
17.	Observation Bed Days				972					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				948			156	7.82	
2.	Rehabilitation Unit									
3.	Psychiatric Unit									
4.	Sub III									
5.	Intensive Care Unit				195					
6.	Coronary Care Unit				77					
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				1,220	1.39%		156	7.82	

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:	26-0180	Medicaid Provider Number:	9993
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	0.629052	337,319			212,191		
2.	Recovery Room	0.295582	15,314			4,527		
3.	Delivery and Labor Room							
4.	Anesthesiology	0.077821	82,328			6,407		
5.	Radiology - Diagnostic	0.215487	446,173			96,144		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.148801	797,372			118,650		
9.	Blood							
10.	Blood - Administration	0.356124	271,819			96,801		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.189209	496,470			93,937		
13.	Physical Therapy	0.408262	34,370			14,032		
14.	Occupational Therapy	0.388273	23,607			9,166		
15.	Speech Pathology	0.467954	10,338			4,838		
16.	EKG	0.140105	659,302			92,372		
17.	EEG	0.077205	18,003			1,390		
18.	Med. / Surg. Supplies	0.280609	176,220			49,449		
19.	Drugs Charged to Patients	0.305517	1,031,282			315,074		
20.	Renal Dialysis	0.191068	273,296			52,218		
21.	Ambulance	0.663164						
22.	CT Scan	0.068971	255,982			17,655		
23.	G.I. Lab	0.333142	20,698			6,895		
23.01	Vascular Lab	0.153219	47,665			7,303		
23.02	Laboratory- Pathology	0.261851	26,489			6,936		
23.03	Shock Therapy	0.771382	6,178			4,766		
23.04	Pain Management & OP Chemo	0.276018	351			97		
23.05	Diabetes Care Center	7.266128						
23.06	O/P Psychology	0.577993						
23.07	Other							
23.08	Other							
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.358894	101,354			36,375		
26.	Observation	0.988293						
27.	Total		5,131,930			1,247,223		

* 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: 26-0180	Medicaid Provider Number: 9993
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 Rehabilitation Unit	Sub II Psychiatric Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 599.55	\$ 503.30	\$ 740.93	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	948			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 568,373	\$	\$	\$
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)	\$ 568,373	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,401.65	195	\$ 273,322
9.	Coronary Care Unit	\$ 1,170.60	77	\$ 90,136
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 1,247,223
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,179,054

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

Medicare Provider Number: 26-0180		Medicaid Provider Number: 9993	
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 (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.	Rehabilitation Unit						
4.	Psychiatric 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: 26-0180	Medicaid Provider Number: 9993
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 (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	364,935	27,739,691	0.013156	337,319			4,438		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	1,778,638	5,772,451	0.308125	82,328			25,367		
5.	Radiology - Diagnostic	28,777	59,731,637	0.000482	446,173			215		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	86,221	80,324,683	0.001073	797,372			856		
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.	G.I. Lab									
23.01	Vascular Lab									
23.02	Laboratory- Pathology									
23.03	Shock Therapy									
23.04	Pain Management & OP Chemo									
23.05	Diabetes Care Center									
23.06	O/P Psychology									
23.07	Other									
23.08	Other									
23.09	Other									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency	1,983,489	35,900,773	0.055249	101,354			5,600		
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	700,002	68,728	10.19	948			9,660		
28.	Rehabilitation Unit									
29.	Psychiatric Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total							46,136		

* 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: 26-0180	Medicaid Provider Number: 9993
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-06 To: 12-31-06

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)	2,179,054		
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)	46,136		
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)	2,225,190		
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)	5,131,930
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	882,661
	B. Rehabilitation Unit	
	C. Psychiatric Unit	
	D. Sub III	
	E. Intensive Care Unit	408,030
	F. Coronary Care Unit	137,305
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	6,559,926
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	4,334,736
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: 26-0180	Medicaid Provider Number: 9993
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 (BHF Page 7, Line 6, Cols. 1, 2, & 3)	2,225,190		
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)	2,225,190		
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)	2,225,190		

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: 26-0180	Medicaid Provider Number: 9993
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 (BHF Page 7, Line 12)	4,334,736
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: 26-0180	Medicaid Provider Number: 9993
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 Rehabilitation Unit	Sub II Psychiatric 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 Rehabilitation Unit	Sub II Psychiatric 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 Rehabilitation Unit	Sub II Psychiatric 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: 26-0180	Medicaid Provider Number: 9993	
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 BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	17,449,707	27,739,691	0.629052
2.	Recovery Room	1,138,585	3,852,009	0.295582
3.	Delivery and Labor Room			
4.	Anesthesiology	449,219	5,772,451	0.077821
5.	Radiology - Diagnostic	12,871,389	59,731,637	0.215487
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	11,952,412	80,324,683	0.148801
9.	Blood			
10.	Blood - Administration	4,280,432	12,019,497	0.356124
11.	Intravenous Therapy			
12.	Respiratory Therapy	5,735,693	30,314,051	0.189209
13.	Physical Therapy	2,722,404	6,668,269	0.408262
14.	Occupational Therapy	1,118,413	2,880,478	0.388273
15.	Speech Pathology	427,201	912,912	0.467954
16.	EKG	4,344,203	31,006,767	0.140105
17.	EEG	276,681	3,583,709	0.077205
18.	Med. / Surg. Supplies	18,749,645	66,817,648	0.280609
19.	Drugs Charged to Patients	16,885,972	55,270,243	0.305517
20.	Renal Dialysis	1,800,743	9,424,609	0.191068
21.	Ambulance	6,577,550	9,918,433	0.663164
22.	CT Scan	1,914,459	27,757,479	0.068971
23.	G.I. Lab	1,311,202	3,935,864	0.333142
23.01	Vascular Lab	567,819	3,705,920	0.153219
23.02	Laboratory- Pathology	816,937	3,119,860	0.261851
23.03	Shock Therapy	142,718	185,016	0.771382
23.04	Pain Management & OP Chemo	867,545	3,143,075	0.276018
23.05	Diabetes Care Center	521,381	71,755	7.266128
23.06	O/P Psychology	424,722	734,822	0.577993
23.07	Other			
23.08	Other			
23.09	Other			
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	12,884,577	35,900,773	0.358894
26.	Observation	583,064	589,971	0.988293
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	41,206,095	68,728	599.55
28.	Rehabilitation Unit	2,312,659	4,595	503.30
29.	Psychiatric Unit	3,071,915	4,146	740.93
30.	Sub III			
31.	Intensive Care Unit	8,914,471	6,360	1,401.65
32.	Coronary Care Unit	5,556,826	4,747	1,170.60
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery			

