

# 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: 01/01/2007	To: 12/31/2007	

## 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 _____

## 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 01/01/2007 and ending 12/31/2007; 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: 01/01/2007 To: 12/31/2007

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	114	41,610		22,823	54.85%		4,877	7.67	
2.										
3.										
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Pediatric ICU	19	6,935		4,025	58.04%				
8.	Neonatal ICU	33	12,045		10,556	87.64%				
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	21	7,765		7,399	95.29%				
16.	Total	187	68,355		44,803	65.54%		4,877	7.67	
17.	Observation Bed Days				1,798					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				4,193			1,344	5.48	
2.										
3.										
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Pediatric ICU				729					
8.	Neonatal ICU				2,449					
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,054					
16.	Total				9,425	21.04%		1,344	5.48	

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: 01/01/2007 To: 12/31/2007

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	0.360658	3,766,910			1,358,566		
2.	Recovery Room	0.297562	212,068			63,103		
3.	Delivery and Labor Room	0.172495						
4.	Anesthesiology	0.207667	784,218			162,856		
5.	Radiology - Diagnostic	0.157317	2,463,614			387,568		
6.	Radiology - Therapeutic	0.234042	22,283			5,215		
7.	Nuclear Medicine	0.208327	2,322			484		
8.	Laboratory	0.160006	4,995,513			799,312		
9.	Anatomic Pathology	0.255814	1,181,270			302,185		
10.	Blood - Administration	0.355639	179,708			63,911		
11.	Intravenous Therapy	1.930602						
12.	Respiratory Therapy	0.208192	5,030,854			1,047,384		
13.	Physical Therapy	0.231920	109,710			25,444		
14.	Occupational Therapy	0.094244	109,426			10,313		
15.	Speech Pathology	0.238057	5,419			1,290		
16.	EKG	0.180369	573,473			103,437		
17.	EEG	0.677147	183,458			124,228		
18.	Med. / Surg. Supplies	0.529282	857			454		
19.	Drugs Charged to Patients	0.216185	6,765,648			1,462,632		
20.	Renal Dialysis	0.274915	63,257			17,390		
21.	Ambulance							
22.	Ultrasound	0.162025	270,508			43,829		
23.	Pain Management	2.166037						
23.01	Cardiac Catheterization	0.160117	95,588			15,305		
23.02	Vascular Lab	0.087359						
23.03	Endoscopy	0.215339						
23.04	Pharmacy-Intravenous DrugsThera	0.285548						
23.05	Sleep Disorder	0.206633	25,675			5,305		
23.06	Psychotherapy	0.213076						
23.07	Clinical Nutrition	3.994367						
23.08	Lab Stem Cell	1.788210	27,630			49,408		
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.904806	18,656			16,880		
25.	Emergency	0.236158						
26.	Observation	0.579692						
27.	<b>Total</b>		26,888,065			6,066,499		

\* 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: 01/01/2007 To: 12/31/2007

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)	\$ 959.65	\$	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,193			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 4,023,812	\$	\$	\$
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)	\$ 4,023,812	\$	\$	\$

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	\$ 1,563.43	729	\$ 1,139,740
11.	Neonatal ICU	\$ 1,474.08	2,449	\$ 3,610,022
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 721.45	2,054	\$ 1,481,858
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 6,066,499
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 16,321,931</b>

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

<b>Medicare Provider Number:</b> 26-0091	<b>Medicaid Provider Number:</b> 19026
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/2007 To: 12/31/2007

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: <b>26-0091</b>	Medicaid Provider Number: <b>19026</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01/01/2007</b> To: <b>12/31/2007</b>

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	383,897	87,494,171	0.004388	3,766,910			16,529		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	3,853,578	25,652,598	0.150222	784,218			117,807		
5.	Radiology - Diagnostic	949,573	101,224,050	0.009381	2,463,614			23,111		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	386,264	10,907,803	0.035412	2,322			82		
8.	Laboratory									
9.	Anatomic Pathology	727,975	9,439,585	0.077119	1,181,270			91,098		
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	254,185	17,778,741	0.014297	573,473			8,199		
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	5,168	26,178,292	0.000197	95,588			19		
23.02	Vascular Lab									
23.03	Endoscopy									
23.04	Pharmacy-Intravenous DrugsTherap									
23.05	Sleep Disorder									
23.06	Psychotherapy									
23.07	Clinical Nutrition									
23.08	Lab Stem Cell									
23.09	Other									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic	131,400	13,573,464	0.009681	18,656			181		
25.	Emergency	3,982,715	68,431,699	0.058200						
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	46,325	24,621	1.88	4,193			7,883		
28.										
29.										
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Pediatric ICU									
34.	Neonatal ICU	394,905	10,556	37.41	2,449			91,617		
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery	5,534	7,399	0.75	2,054			1,541		
37.	<b>Total</b>							358,067		

\* 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: 01/01/2007 To: 12/31/2007

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)	16,321,931		
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)	358,067		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	16,679,998		
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)	26,888,065
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	9,023,190
	B.	
	C.	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Pediatric ICU	2,962,233
	H. Neonatal ICU	8,441,503
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	5,784,782
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	53,099,773
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	36,419,775
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: 01/01/2007 To: 12/31/2007

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)	16,679,998		
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)	16,679,998		
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	16,679,998		

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* 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: 01/01/2007 To: 12/31/2007

**Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges**

<b>Line No.</b>	(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)	36,419,775
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.	<b>Total (Sum of Lines 1 - 3)</b>							

**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: 01/01/2007 To: 12/31/2007

**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

<b>Medicare Provider Number:</b> 26-0091	<b>Medicaid Provider Number:</b> 19026	
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/2007	<b>To:</b> 12/31/2007

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	31,555,500	87,494,171	0.360658
2.	Recovery Room	2,648,258	8,899,862	0.297562
3.	Delivery and Labor Room	4,609,257	26,721,123	0.172495
4.	Anesthesiology	5,327,208	25,652,598	0.207667
5.	Radiology - Diagnostic	15,924,279	101,224,050	0.157317
6.	Radiology - Therapeutic	1,896,489	8,103,187	0.234042
7.	Nuclear Medicine	2,272,386	10,907,803	0.208327
8.	Laboratory	18,156,382	113,473,057	0.160006
9.	Anatomic Pathology	2,414,782	9,439,585	0.255814
10.	Blood - Administration	4,772,647	13,419,911	0.355639
11.	Intravenous Therapy	1,033,849	535,506	1.930602
12.	Respiratory Therapy	8,508,648	40,869,323	0.208192
13.	Physical Therapy	2,453,939	10,580,970	0.231920
14.	Occupational Therapy	672,173	7,132,259	0.094244
15.	Speech Pathology	1,114,057	4,679,788	0.238057
16.	EKG	3,206,742	17,778,741	0.180369
17.	EEG	1,232,144	1,819,612	0.677147
18.	Med. / Surg. Supplies	41,104,292	77,660,430	0.529282
19.	Drugs Charged to Patients	15,267,496	70,622,468	0.216185
20.	Renal Dialysis	1,990,928	7,241,979	0.274915
21.	Ambulance			
22.	Ultrasound	1,545,281	9,537,271	0.162025
23.	Pain Management	293,602	135,548	2.166037
23.01	Cardiac Catheterization	4,191,594	26,178,292	0.160117
23.02	Vascular Lab	1,160,963	13,289,577	0.087359
23.03	Endoscopy	3,866,048	17,953,289	0.215339
23.04	Pharmacy-Intravenous DrugsTherapy	10,732,759	37,586,499	0.285548
23.05	Sleep Disorder	519,853	2,515,827	0.206633
23.06	Psychotherapy	1,823,602	8,558,451	0.213076
23.07	Clinical Nutrition	1,043,784	261,314	3.994367
23.08	Lab Stem Cell	213,591	119,444	1.788210
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	12,281,355	13,573,464	0.904806
25.	Emergency	16,160,676	68,431,699	0.236158
26.	Observation	5,413,127	9,337,944	0.579692
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	23,627,488	24,621	959.65
28.				
29.				
30.	Sub III			
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Pediatric ICU	6,292,805	4,025	1,563.43
34.	Neonatal ICU	15,560,403	10,556	1,474.08
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	5,338,011	7,399	721.45

**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: 01/01/2007 To: 12/31/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,371		7,371
Newborn Days	2,054		2,054
Total Inpatient Revenue	53,099,763	10	53,099,773
Ancillary Revenue	26,888,065		26,888,065
Routine Revenue	26,211,698	10	26,211,708
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
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.