

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: 01/01/2007	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 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 01/01/2007 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: 19035
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	351	128,115		67,457	52.65%		N/A		
2.	Psychiatric Unit	37	13,505		11,096	82.16%				
3.	Rehabilitation Unit	3	1,095		662	60.46%				
4.	Sub III									
5.	Intensive Care Unit	12	4,380		3,374	77.03%				
6.	Coronary Care Unit	12	4,380		3,766	85.98%				
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	48	17,520		14,260	81.39%				
16.	Total	463	168,995		100,615	59.54%				
17.	Observation Bed Days				5,312					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,543			N/A		
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				31					
6.	Coronary Care Unit				12					
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,784					
16.	Total				4,370	4.34%				

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

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	0.360658	189,887			68,484		
2.	Recovery Room	0.297562	18,592			5,532		
3.	Delivery and Labor Room	0.172495	2,245,400			387,320		
4.	Anesthesiology	0.207667	160,653			33,362		
5.	Radiology - Diagnostic	0.157317	260,132			40,923		
6.	Radiology - Therapeutic	0.234042	10,930			2,558		
7.	Nuclear Medicine	0.208327	53,098			11,062		
8.	Laboratory	0.160006	1,106,372			177,026		
9.	Anatomic Pathology	0.255814	90,740			23,213		
10.	Blood - Administration	0.355639	205,042			72,921		
11.	Intravenous Therapy	1.930602	1,500			2,896		
12.	Respiratory Therapy	0.208192	807,374			168,089		
13.	Physical Therapy	0.231920						
14.	Occupational Therapy	0.094244	149			14		
15.	Speech Pathology	0.238057	1,781			424		
16.	EKG	0.180369	19,831			3,577		
17.	EEG	0.677147						
18.	Med. / Surg. Supplies	0.529282						
19.	Drugs Charged to Patients	0.216185	613,955			132,728		
20.	Renal Dialysis	0.274915	1,819			500		
21.	Ambulance							
22.	Ultrasound	0.162025						
23.	Pain Management	2.166037						
23.01	Cardiac Catheterization	0.160117	215,132			34,446		
23.02	Vascular Lab	0.087359						
23.03	Endoscopy	0.215339	35,805			7,710		
23.04	Pharmacy-Intravenous DrugsThera	0.285548	704,564			201,187		
23.05	Sleep Disorder	0.206633						
23.06	Psychotherapy	0.213076						
23.07	Clinical Nutrition	3.994367	78			312		
23.08	Lab Stem Cell	1.788210						
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic	0.904806	223			202		
25.	Emergency	0.236158						
26.	Observation	0.579692						
27.	Total		6,743,057			1,374,486		

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

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 959.65	\$ 554.85	\$ 959.65	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,543			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,480,740	\$	\$	\$
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)	\$ 1,480,740	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,709.13	31	\$ 52,983
9.	Coronary Care Unit	\$ 1,375.56	12	\$ 16,507
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 721.45	2,784	\$ 2,008,517
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 1,374,486
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 4,933,233

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

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	189,887			833		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	3,853,578	25,652,598	0.150222	160,653			24,134		
5.	Radiology - Diagnostic	949,573	101,224,050	0.009381	260,132			2,440		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	386,264	10,907,803	0.035412	53,098			1,880		
8.	Laboratory									
9.	Anatomic Pathology	727,975	9,439,585	0.077119	90,740			6,998		
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	19,831			284		
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	215,132			42		
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									
Outpatient Ancillary Cost Centers										
24.	Clinic	131,400	13,573,464	0.009681	223			2		
25.	Emergency	3,982,715	68,431,699	0.058200						
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	136,920	72,769	1.88	1,543			2,901		
28.	Psychiatric Unit	2,465	11,096	0.22						
29.	Rehabilitation Unit	1,246	662	1.88						
30.	Sub III									
31.	Intensive Care Unit	44,182	3,374	13.09	31			406		
32.	Coronary Care Unit	44,135	3,766	11.72	12			141		
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery	10,666	14,260	0.75	2,784			2,088		
37.	Total							42,149		

* 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: 01/01/2007 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)	4,933,233		
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)	42,149		
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)	4,975,382		
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)	6,743,057
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,537,957
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	97,102
	F. Coronary Care Unit	38,137
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	4,484,078
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	13,900,331
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	8,924,949
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: 01/01/2007 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)	4,975,382		
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)	4,975,382		
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)	4,975,382		

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

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)	8,924,949
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: 01/01/2007 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 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: 01/01/2007	To: 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)
Inpatient Ancillary Centers				
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			
Outpatient Ancillary Centers				
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
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	69,832,615	72,769	959.65
28.	Psychiatric Unit	6,156,625	11,096	554.85
29.	Rehabilitation Unit	635,287	662	959.65
30.	Sub III			
31.	Intensive Care Unit	5,766,610	3,374	1,709.13
32.	Coronary Care Unit	5,180,376	3,766	1,375.56
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	10,287,881	14,260	721.45

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,586		1,586
Newborn Days	2,784		2,784
Total Inpatient Revenue	13,995,238	(94,907)	13,900,331
Ancillary Revenue	6,837,964	(94,907)	6,743,057
Routine Revenue	7,157,274		7,157,274
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.
- _____ Removed Medicaid Cardiac Rehab charges of \$94,907. Cardiac Rehab is non-covered for Illinois Medicaid.
- _____ 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.
- _____
- _____