

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. John's Mercy Medical Center		Medicare Provider Number: 26-0020
Street: 615 South New Ballas Road		Medicaid Provider Number: 19029
City: St. Louis	State: Missouri	Zip: 63141
Period Covered by Statement:	From: 07-01-20065	To: 06-30-2007

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" 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) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<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 type="checkbox"/> Medicaid Hospital	<input checked="" type="checkbox"/> Medicaid Sub II Rehabilitation	<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. John's Mercy Medical Cen 19029 for the cost report beginning 07-01-2006 and ending 06-30-200 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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	530	193,450		133,697	69.11%		37,252	5.07	
2.	Psych Center	48	17,520		15,392	87.85%		2,451	6.28	
3.	Rehab Center	46	16,790		13,818	82.30%		858	16.10	
4.	Sub III									
5.	Intensive Care Unit	54	19,710		14,476	73.44%				
6.	Coronary Care Unit	96	35,040		16,617	47.42%				
7.	Neonatal Intensive Care Unit	85	31,025		23,994	77.34%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	80	29,200		19,545	66.93%				
16.	Total	939	342,735		237,539	69.31%		40,561	5.37	
17.	Observation Bed Days				5,423					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psych Center									
3.	Rehab Center				197			8	24.63	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal Intensive Care Unit									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				197	0.08%		8	24.63	

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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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	0.459325	38,924			17,879		
2.	Recovery Room	0.136950	2,653			363		
3.	Delivery and Labor Room	0.392059						
4.	Anesthesiology	0.218505	3,570			780		
5.	Radiology - Diagnostic	0.259125	9,386			2,432		
6.	Radiology - Therapeutic	0.243367	6,564			1,597		
7.	Nuclear Medicine	0.154659	1,504			233		
8.	Laboratory	0.110862	56,218			6,232		
9.	Blood							
10.	Blood - Administration	0.379691						
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.190461	17,433			3,320		
13.	Physical Therapy	0.412845	152,274			62,866		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.210250	4,959			1,043		
17.	EEG							
18.	Med. / Surg. Supplies	0.168637	31,823			5,367		
19.	Drugs Charged to Patients	0.206708	106,046			21,921		
20.	Renal Dialysis	0.466821	13,792			6,438		
21.	Ambulance	1.649708						
22.	Ultrasound	0.132504	567			75		
23.	CT Scan	0.062114	17,694			1,099		
23.01	Magnetic Resonance Imaging	0.125015	6,987			873		
23.02	Oncology	0.404011						
23.03	Laboratory- Pathological	0.186351						
23.04	ASC (Non-distinct Part)	0.342663	560			192		
23.05	Cardiac Catheterization Laboratory	0.271835						
23.06	Gastrointestinal Services	0.143195						
23.07	Electroconvulsive Therapy	0.279165						
23.08	O/P Psych	0.784041						
23.09	Hyperbaric/OP Wound Center	0.445305						
Outpatient Service Cost Centers								
24.	Clinic	3.900301						
25.	Emergency	0.263041						
26.	Observation	0.361171						
27.	Total		470,954			132,710		

* 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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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

Line No.	Description	Adults and Pediatrics	Sub I Psych Center	Sub II Rehab Center	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 763.36	\$ 664.99	\$ 525.56	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			197	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 103,535	\$
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)	\$	\$	\$ 103,535	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,347.77		\$
9.	Coronary Care Unit	\$ 1,130.79		\$
10.	Neonatal Intensive Care Unit	\$ 816.43		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 471.53		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 132,710
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 236,245

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

Medicare Provider Number: 26-0020		Medicaid Provider Number: 19029	
Program: Medicaid-Rehabilitation		Period Covered by Statement: From: 07-01-20065 To: 06-30-2007	

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.	Psych Center						
4.	Rehab Center						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal Intensive Care Unit						
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:	26-0020	Medicaid Provider Number:	19029
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07-01-20065 To: 06-30-2007

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	84,510	175,067,221	0.000483	38,924			19		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	16,770	87,920,256	0.000191	9,386			2		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	242,429	190,178,122	0.001275	56,218			72		
9.	Blood									
10.	Blood - Administration	29,164	23,118,611	0.001261						
11.	Intravenous Therapy									
12.	Respiratory Therapy	76,569	68,434,198	0.001119	17,433			20		
13.	Physical Therapy	1,075,058	46,904,886	0.022920	152,274			3,490		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	3,197,974	97,590,940	0.032769	4,959			163		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound	1,501,100	25,946,296	0.057854	567			33		
23.	CT Scan									
23.01	Magnetic Resonance Imaging									
23.02	Oncology									
23.03	Laboratory- Pathological									
23.04	ASC (Non-distinct Part)									
23.05	Cardiac Catheterization Laboratory	13,500	70,615,590	0.000191						
23.06	Gastrointestinal Services	14,790	46,088,295	0.000321						
23.07	Electroconvulsive Therapy									
23.08	O/P Psych									
23.09	Hyperbaric/OP Wound Center	206,590	2,239,597	0.092244						
Outpatient Ancillary Cost Centers										
24.	Clinic	291,057	1,929,946	0.150811						
25.	Emergency	5,274,741	75,848,824	0.069543						
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	1,155,005	139,120	8.30						
28.	Psych Center	304,465	15,392	19.78						
29.	Rehab Center									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit	2,412,869	16,617	145.20						
33.	Neonatal Intensive Care Unit	256,388	23,994	10.69						
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total							3,799		

* 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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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)	236,245		
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)	3,799		
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)	240,044		
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)	470,954
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psych Center	
	C. Rehab Center	202,851
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal Intensive Care Unit	
	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)	673,805
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	433,761
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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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)	240,044		
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)	240,044		
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)	240,044		

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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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)	433,761
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 (4)	Sum of Columns 1 - 4 (5)
		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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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 Psych Center	Sub II Rehab Center	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 Psych Center	Sub II Rehab Center	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 Psych Center	Sub II Rehab Center	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: 26-0020	Medicaid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-20065 To: 06-30-2007

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	80,412,752	175,067,221	0.459325
2.	Recovery Room	3,632,267	26,522,482	0.136950
3.	Delivery and Labor Room	14,740,437	37,597,495	0.392059
4.	Anesthesiology	7,326,177	33,528,599	0.218505
5.	Radiology - Diagnostic	22,782,331	87,920,256	0.259125
6.	Radiology - Therapeutic	8,197,541	33,683,857	0.243367
7.	Nuclear Medicine	5,150,067	33,299,469	0.154659
8.	Laboratory	21,083,569	190,178,122	0.110862
9.	Blood			
10.	Blood - Administration	8,777,920	23,118,611	0.379691
11.	Intravenous Therapy			
12.	Respiratory Therapy	13,034,025	68,434,198	0.190461
13.	Physical Therapy	19,364,461	46,904,886	0.412845
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	20,518,497	97,590,940	0.210250
17.	EEG			
18.	Med. / Surg. Supplies	8,252,961	48,939,107	0.168637
19.	Drugs Charged to Patients	40,329,711	195,104,997	0.206708
20.	Renal Dialysis	5,040,882	10,798,317	0.466821
21.	Ambulance	34,502	20,914	1.649708
22.	Ultrasound	3,437,993	25,946,296	0.132504
23.	CT Scan	5,701,526	91,791,064	0.062114
23.01	Magnetic Resonance Imaging	4,266,728	34,129,778	0.125015
23.02	Oncology	1,703,664	4,216,879	0.404011
23.03	Laboratory- Pathological	2,966,980	15,921,478	0.186351
23.04	ASC (Non-distinct Part)	5,771,135	16,842,002	0.342663
23.05	Cardiac Catheterization Laboratory	19,195,780	70,615,590	0.271835
23.06	Gastrointestinal Services	6,599,617	46,088,295	0.143195
23.07	Electroconvulsive Therapy	485,354	1,738,590	0.279165
23.08	O/P Psych	1,141,642	1,456,100	0.784041
23.09	Hyperbaric/OP Wound Center	997,303	2,239,597	0.445305
Outpatient Ancillary Centers				
24.	Clinic	7,527,371	1,929,946	3.900301
25.	Emergency	19,951,328	75,848,824	0.263041
26.	Observation	3,839,050	10,629,459	0.361171
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	106,198,830	139,120	763.36
28.	Psych Center	10,235,486	15,392	664.99
29.	Rehab Center	7,262,242	13,818	525.56
30.	Sub III			
31.	Intensive Care Unit	19,510,371	14,476	1,347.77
32.	Coronary Care Unit	18,790,403	16,617	1,130.79
33.	Neonatal Intensive Care Unit	19,589,481	23,994	816.43
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	9,216,084	19,545	471.53

