

# Hospital Statement of Cost

Illinois Department of Public Aid, Office 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		Public Aid Provider Number: 19029	
City: St. Louis	State: Missouri	Zip: 63141	
Period Covered by Statement:	From: 07-01-01	To: 06-30-02	

## 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 checked="" type="checkbox"/> Medicaid Hospital	<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. John's Mercy Medical Cen 19029 for the cost report beginning 07-01-01 and ending 06-30-02 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 Public Aid 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	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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	567	206,802		111,444	53.89%		28,561	5.05	
2.	Psych Center	78	28,370		18,226	64.24%		2,891	6.30	
3.	Rehab Center	41	14,965		9,293	62.10%		567	16.39	
4.										
5.	Intensive Care Unit	40	14,600		10,532	72.14%				
6.	Coronary Care Unit	16	5,840		5,018	85.92%				
7.	Neonatal Care Unit	48	17,520		17,293	98.70%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	97	35,405		14,069	39.74%				
16.	Total	887	323,502		185,875	57.46%		32,019	5.37	
17.	Observation Bed Days				6,793					

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				170			46	8.85	
2.	Psych Center									
3.	Rehab Center									
4.										
5.	Intensive Care Unit				5					
6.	Coronary Care Unit									
7.	Neonatal Care Unit				232					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				3					
16.	Total				410	0.22%		46	8.85	

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	Public Aid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-01 To: 06-30-02

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	0.445042	40,952			18,225		
2.	Recovery Room	0.261931	4,193			1,098		
3.	Delivery and Labor Room	0.628808	7,082			4,453		
4.	Anesthesiology	0.238952	7,635			1,824		
5.	Radiology - Diagnostic	0.314231	21,010			6,602		
6.	Radiology - Therapeutic	0.451223	652			294		
7.	Radioisotope	0.226629						
8.	Laboratory	0.170498	89,579			15,273		
9.	Hyperbaric/ OP Wound	1.000849						
10.	Blood - Administration	0.550447	13,715			7,549		
11.	Pain Therapy Center	1.599172						
12.	Respiratory Therapy	0.239387	225,527			53,988		
13.	Physical Therapy	0.556306	33,005			18,361		
14.	Observation Beds (Distinct Part)	0.590778	90			53		
15.	Kidney Acquisition [per W/S D-6]							
16.	EKG	0.256847	18,487			4,748		
17.	EEG							
18.	Med. / Surg. Supplies	0.114393	112,677			12,889		
19.	Drugs Charged to Patients	0.286676	138,340			39,659		
20.	Renal Dialysis	0.380288						
21.	Ambulance	1.163788						
22.	Ultrasound	0.130582	4,286			560		
23.	CT Scan	0.071701	22,540			1,616		
23.01	Magnetic Resonance Imaging	0.191435	3,295			631		
23.02	Oncology	0.816477						
23.03	Laboratory- Pathological	0.722532	196			142		
23.04	ASC (Non-distinct Part)	0.511532	1,242			635		
23.05	Cardiac Catheterization Laboratory	0.299519	4,685			1,403		
23.06	Gastrointestinal Services	0.403346	613			247		
23.07	Electroconvulsive Therapy	0.333881						
23.08	O/P Psych	0.502432						
23.09	Natural Family Planning	3.273493						
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	4.581185						
25.	Emergency	0.341005	28,411			9,688		
26.	Observation Beds (Non-distinct Part)	1.615437						
27.	<b>Total</b>		778,212			199,938		

\* 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	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 554.90	\$ 541.59	\$ 598.15	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	170			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 94,333	\$	\$	\$
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 (OHF 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)	\$ 94,333	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 940.29	5	\$ 4,701
9.	Coronary Care Unit	\$ 1,379.50		\$
10.	Neonatal Care Unit	\$ 611.70	232	\$ 141,914
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 276.27	3	\$ 829
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 199,938
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 441,715</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> 26-0020	<b>Public Aid Provider Number:</b> 19029
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07-01-01 To: 06-30-02

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 (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF 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.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal Care Unit						
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
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 Beds (Non-distinct F										
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	Public Aid Provider Number:	19029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-01 To: 06-30-02

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 (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF 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	2,310,029	102,376,676	0.022564	40,952			924		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	72,280	35,638,652	0.002028	21,010			43		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	277,177	78,996,082	0.003509	89,579			314		
9.	Hyperbaric/ OP Wound									
10.	Blood - Administration	22,767	11,415,872	0.001994	13,715			27		
11.	Pain Therapy Center	66,437	122,676	0.541565						
12.	Respiratory Therapy									
13.	Physical Therapy	186,253	20,873,548	0.008923	33,005			295		
14.	Observation Beds (Distinct Part)									
15.	Kidney Acquisition [per W/S D-6]									
16.	EKG	1,981,721	49,175,319	0.040299	18,487			745		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	CT Scan									
23.01	Magnetic Resonance Imaging									
23.02	Oncology									
23.03	Laboratory- Pathological									
23.04	ASC (Non-distinct Part)	25,600	8,786,632	0.002914	1,242			4		
23.05	Cardiac Catheterization Laboratory									
23.06	Gastrointestinal Services									
23.07	Electroconvulsive Therapy									
23.08	O/P Psych									
23.09	Natural Family Planning									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic	31,713	991,222	0.031994						
25.	Emergency	3,551,263	31,882,387	0.111386	28,411			3,165		
26.	Observation Beds (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	6,349,615	118,237	53.70	170			9,129		
28.	Psych Center	270,394	18,226	14.84						
29.	Rehab Center									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	2,483,660	5,018	494.95						
33.	Neonatal Care Unit	160,650	17,293	9.29	232			2,155		
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							16,801		

\* 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	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	441,715		
3.	Interns and Residents Not in an Approved Teaching Program (OHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (OHF Page 6, Line 37, Cols. 6 & 7)	16,801		
5.	Services of Teaching Physicians (OHF 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>	458,516		
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)	778,212
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	187,712
	B. Psych Center	
	C. Rehab Center	
	D.	
	E. Intensive Care Unit	7,500
	F. Coronary Care Unit	
	G. Neonatal Care Unit	419,722
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	579
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	1,393,725
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	935,209
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	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	458,516		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	458,516		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF 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>	458,516		

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: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

**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 (OHF Page 7, Line 12)	935,209
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 (OHF 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**

OHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

**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
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

**Part C. Program Cost**

	General Service	Sub I Psych Center	Sub II Rehab Center	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I Psych Center	Sub II Rehab Center	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 OHF 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 OHF Page 4, Line 1)				

**Hospital Statement of Cost  
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

**PRELIMINARY**

<b>Medicare Provider Number:</b> 26-0020	<b>Public Aid Provider Number:</b> 19029
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07-01-01 To: 06-30-02

**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 OHF pgs. 3-4)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	45,561,946	102,376,676	0.445042
2.	Recovery Room	2,514,086	9,598,286	0.261931
3.	Delivery and Labor Room	10,102,638	16,066,340	0.628808
4.	Anesthesiology	4,674,287	19,561,648	0.238952
5.	Radiology - Diagnostic	11,198,787	35,638,652	0.314231
6.	Radiology - Therapeutic	4,767,259	10,565,194	0.451223
7.	Radioisotope	2,571,061	11,344,820	0.226629
8.	Laboratory	13,468,690	78,996,082	0.170498
9.	Hyperbaric/ OP Wound	826,133	825,432	1.000849
10.	Blood - Administration	6,283,831	11,415,872	0.550447
11.	Pain Therapy Center	196,180	122,676	1.599172
12.	Respiratory Therapy	6,396,015	26,718,286	0.239387
13.	Physical Therapy	11,612,085	20,873,548	0.556306
14.	Observation Beds (Distinct Part)	1,567,890	2,653,940	0.590778
15.	Kidney Acquisition [per W/S D-6]			
16.	EKG	12,630,542	49,175,319	0.256847
17.	EEG			
18.	Med. / Surg. Supplies	4,305,748	37,639,831	0.114393
19.	Drugs Charged to Patients	24,448,796	85,283,792	0.286676
20.	Renal Dialysis	744,505	1,957,738	0.380288
21.	Ambulance	72,774	62,532	1.163788
22.	Ultrasound	753,101	5,767,269	0.130582
23.	CT Scan	2,194,864	30,611,428	0.071701
23.01	Magnetic Resonance Imaging	2,635,638	13,767,802	0.191435
23.02	Oncology	1,080,922	1,323,886	0.816477
23.03	Laboratory- Pathological	2,972,322	4,113,759	0.722532
23.04	ASC (Non-distinct Part)	4,494,641	8,786,632	0.511532
23.05	Cardiac Catheterization Laboratory	7,104,080	23,718,326	0.299519
23.06	Gastrointestinal Services	3,675,131	9,111,603	0.403346
23.07	Electroconvulsive Therapy	381,086	1,141,381	0.333881
23.08	O/P Psych	1,150,699	2,290,259	0.502432
23.09	Natural Family Planning	146,515	44,758	3.273493
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	4,540,971	991,222	4.581185
25.	Emergency	10,872,043	31,882,387	0.341005
26.	Observation Beds (Non-distinct Part)	3,337,605	2,066,069	1.615437
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	65,609,387	118,237	554.90
28.	Psych Center	9,871,003	18,226	541.59
29.	Rehab Center	5,558,598	9,293	598.15
30.				
31.	Intensive Care Unit	9,903,092	10,532	940.29
32.	Coronary Care Unit	6,922,346	5,018	1,379.50
33.	Neonatal Care Unit	10,578,199	17,293	611.70
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	3,886,839	14,069	276.27

