

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. Mary's Health Center		Medicare Provider Number: 26-0091	
Street: 6420 Clayton Road		Public Aid Provider Number: 19035	
City: St. Louis	State: Missouri	Zip: 63117	
Period Covered by Statement:	From: 01-01-03	To: 12-31-03	

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 01-01-03 and ending 12-31-03 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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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	348	127,020	17,545	67,340	53.02%		16,513	4.49	
2.	Psychiatric Unit	38	13,870	106	9,075	65.43%		1,159	7.83	
3.										
4.										
5.	Intensive Care Unit	12	4,380		3,216	73.42%				
6.	Coronary Care Unit	12	4,380		3,595	82.08%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	48	17,520		12,359	70.54%				
16.	Total	458	167,170	17,651	95,585	57.18%		17,672	4.71	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,947			298	6.74	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				30					
6.	Coronary Care Unit				31					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,553					
16.	Total				3,561	3.73%		298	6.74	

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	Public Aid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-03 To: 12-31-03

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	0.380094	390,985			148,611		
2.	Recovery Room	0.267519	15,510			4,149		
3.	Delivery and Labor Room	0.312917	1,479,139			462,848		
4.	Anesthesiology	0.244863	121,813			29,827		
5.	Radiology - Diagnostic	0.160079	192,509			30,817		
6.	Radiology - Therapeutic	0.225467	8,721			1,966		
7.	Nuclear Medicine	0.186496	5,554			1,036		
8.	Laboratory	0.190484	760,248			144,815		
9.	Anatomic Pathology	0.175620	56,513			9,925		
10.	Blood - Administration	0.485339	115,566			56,089		
11.	Intravenous Therapy	0.336813	48,134			16,212		
12.	Respiratory Therapy	0.152146	1,231,892			187,427		
13.	Physical Therapy	0.529085	11,574			6,124		
14.	Occupational Therapy	0.346134	1,355			469		
15.	Speech Pathology	0.430264	1,354			583		
16.	EKG	0.146628	10,170			1,491		
17.	EEG	0.464456						
18.	Med. / Surg. Supplies	0.103013	11,405			1,175		
19.	Drugs Charged to Patients	0.399107	312,671			124,789		
20.	Renal Dialysis	0.254832	8,678			2,211		
21.	Transport Services	1.351157						
22.	Ultrasound	0.188379	37,528			7,069		
23.	Pain Management	0.195897	1,304			255		
23.01	Cardiac Catheterization	0.229990	116,680			26,835		
23.02	Vascular Lab	0.114568	77,851			8,919		
23.03	Endoscopy	0.171263	24,429			4,184		
23.04	Pharmacy-Intravenous DrugsThera	0.225791	673,551			152,082		
23.05	Sleep Disorder	0.242546						
23.06	Psychotherapy	0.304857						
23.07	Clinical Nutrition	2.463539	20			49		
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic	1.325089						
25.	Emergency	0.292983						
26.	Observation Beds (Non-distinct Par							
27.	Total		5,715,154			1,429,957		

* 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	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 703.26	\$ 462.76	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,947			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,369,247	\$	\$	\$
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)	\$ 1,369,247	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,337.88	30	\$ 40,136
9.	Coronary Care Unit	\$ 1,310.83	31	\$ 40,636
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 696.97	1,553	\$ 1,082,394
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,429,957
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 3,962,370

**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	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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.	Psychiatric Unit						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.							
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:	26-0091	Public Aid Provider Number:	19035
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-03 To: 12-31-03

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	104,069	99,460,920	0.001046	390,985			409		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	19,366	22,978,429	0.000843	121,813			103		
5.	Radiology - Diagnostic	932,562	84,360,396	0.011055	192,509			2,128		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	444,513	9,625,578	0.046180	5,554			256		
8.	Laboratory	831,588	81,212,112	0.010240	760,248			7,785		
9.	Anatomic Pathology	34,690	9,029,958	0.003842	56,513			217		
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	245,702	13,488,675	0.018215	10,170			185		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Transport Services									
22.	Ultrasound									
23.	Pain Management									
23.01	Cardiac Catheterization	5,000	32,227,242	0.000155	116,680			18		
23.02	Vascular Lab									
23.03	Endoscopy	52,520	17,874,883	0.002938	24,429			72		
23.04	Pharmacy-Intravenous DrugsTherap									
23.05	Sleep Disorder									
23.06	Psychotherapy	22,000	5,368,927	0.004098						
23.07	Clinical Nutrition									
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic	54,584	8,187,520	0.006667						
25.	Emergency	2,807,361	54,880,695	0.051154						
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	40,258	67,340	0.60	1,947			1,168		
28.	Psychiatric Unit	24,000	9,075	2.64						
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	41,274	3,595	11.48	31			356		
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							12,697		

* 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	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)	3,962,370		
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)	12,697		
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	3,975,067		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	5,715,154
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,064,462
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	77,471
	F. Coronary Care Unit	112,330
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	2,564,004
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	10,533,421
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	6,558,354
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	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)	3,975,067		
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)	3,975,067		
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.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	3,975,067		

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	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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 (OHF Page 7, Line 12)	6,558,354
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.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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	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 Psychiatric Unit	Sub II	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 Psychiatric Unit	Sub II	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, 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

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)
Inpatient Ancillary Centers				
1.	Operating Room	37,804,525	99,460,920	0.380094
2.	Recovery Room	2,183,564	8,162,271	0.267519
3.	Delivery and Labor Room	6,207,085	19,836,203	0.312917
4.	Anesthesiology	5,626,563	22,978,429	0.244863
5.	Radiology - Diagnostic	13,504,364	84,360,396	0.160079
6.	Radiology - Therapeutic	1,388,321	6,157,548	0.225467
7.	Nuclear Medicine	1,795,129	9,625,578	0.186496
8.	Laboratory	15,469,643	81,212,112	0.190484
9.	Anatomic Pathology	1,585,843	9,029,958	0.175620
10.	Blood - Administration	5,238,585	10,793,665	0.485339
11.	Intravenous Therapy	973,587	2,890,585	0.336813
12.	Respiratory Therapy	7,577,954	49,807,036	0.152146
13.	Physical Therapy	1,692,988	3,199,842	0.529085
14.	Occupational Therapy	480,107	1,387,056	0.346134
15.	Speech Pathology	910,158	2,115,350	0.430264
16.	EKG	1,977,811	13,488,675	0.146628
17.	EEG	707,730	1,523,782	0.464456
18.	Med. / Surg. Supplies	72,069	699,610	0.103013
19.	Drugs Charged to Patients	15,257,613	38,229,421	0.399107
20.	Renal Dialysis	1,545,751	6,065,753	0.254832
21.	Transport Services	1,908,094	1,412,193	1.351157
22.	Ultrasound	1,221,854	6,486,160	0.188379
23.	Pain Management	605,182	3,089,280	0.195897
23.01	Cardiac Catheterization	7,411,936	32,227,242	0.229990
23.02	Vascular Lab	977,589	8,532,840	0.114568
23.03	Endoscopy	3,061,310	17,874,883	0.171263
23.04	Pharmacy-Intravenous DrugsTherapy	9,173,835	40,629,768	0.225791
23.05	Sleep Disorder	140,495	579,251	0.242546
23.06	Psychotherapy	1,636,757	5,368,927	0.304857
23.07	Clinical Nutrition	828,929	336,479	2.463539
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic	10,849,193	8,187,520	1.325089
25.	Emergency	16,079,095	54,880,695	0.292983
26.	Observation Beds (Non-distinct Part)			
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	47,357,332	67,340	703.26
28.	Psychiatric Unit	4,199,544	9,075	462.76
29.				
30.				
31.	Intensive Care Unit	4,302,608	3,216	1,337.88
32.	Coronary Care Unit	4,712,422	3,595	1,310.83
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	8,613,852	12,359	696.97

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,008		2,008
Newborn Days	1,553		1,553
Total Inpatient Revenue	10,533,421		10,533,421
Ancillary Revenue	5,715,154		5,715,154
Routine Revenue	4,818,267		4,818,267
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 that CCU Bed Days Available = 4,380. Number of CCU Beds = 12 for FYE 12-31-99, 12-31-00, 12-31-01, 12-31-02, and 12-31-03.

Filed OHF Supplement No. 2 charges for Radiology-Diagnostic, Nuclear Medicine, Laboratory, Anatomic Pathology, EKG, Ultrasound, Clinic and ER are greater than the W/S C charges.

Omitted the private-room calculation that would be on Supplement No. 1. There are no private-rooms days

for Illinois Medicaid and there are no private-room days allocated to Cardinal Glennon Children's Hospital.