

# 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: 01/01/04	To: 12/31/04

**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 01/01/04 and ending 12/31/04 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: 01/01/04 To: 12/31/04

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	127,368	24,037	64,556	50.68%		16,840	4.23	
2.	Psychiatric Unit	38	13,908	197	9,991	71.84%		1,254	7.97	
3.										
4.										
5.	Intensive Care Unit	12	4,392		3,066	69.81%				
6.	Coronary Care Unit	12	4,392		3,668	83.52%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	48	17,520		14,712	83.97%				
16.	Total	458	167,580	24,234	95,993	57.28%		18,094	4.49	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				2,054			291	7.31	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				34					
6.	Coronary Care Unit				38					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,982					
16.	Total				4,108	4.28%		291	7.31	

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: 01/01/04 To: 12/31/04

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	0.385953	306,277			118,209		
2.	Recovery Room	0.285075	20,618			5,878		
3.	Delivery and Labor Room	0.333658	1,810,551			604,105		
4.	Anesthesiology	0.153843	146,549			22,546		
5.	Radiology - Diagnostic	0.161880	198,635			32,155		
6.	Radiology - Therapeutic	0.217248						
7.	Nuclear Medicine	0.204199	12,678			2,589		
8.	Laboratory	0.176233	777,704			137,057		
9.	Blood-Administration	0.440189	153,712			67,662		
10.	Anatomic Pathology	0.297654	63,506			18,903		
11.	Intravenous Therapy	0.543806	19,414			10,557		
12.	Respiratory Therapy	0.144727	1,026,458			148,556		
13.	Physical Therapy	0.461300	10,452			4,822		
14.	Occupational Therapy	0.313933	704			221		
15.	Speech Pathology	0.417577	1,546			646		
16.	EKG	0.148102	15,937			2,360		
17.	EEG	0.585959						
18.	Med. / Surg. Supplies	3.160175						
19.	Drugs Charged to Patients	0.271152	438,487			118,897		
20.	Renal Dialysis	0.272330	14,227			3,874		
21.	Transport Services	1.297165						
22.	Ultrasound	0.170429	39,104			6,664		
23.	Pain Management	0.136431						
23.01	Cardiac Catheterization	0.220404	25,019			5,514		
23.02	Vascular Lab	0.102018	100,878			10,291		
23.03	Endoscopy	0.201087	4,666			938		
23.04	Pharmacy-Intravenous DrugsThera	0.216476	1,047,272			226,709		
23.05	Sleep Disorder	0.307232						
23.06	Psychotherapy	0.215792						
23.07	Clinical Nutrition	6.165278						
23.08	Lab Stem Cell	2.349625						
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	1.215630						
25.	Emergency	0.318574						
26.	Observation Beds (Non-distinct Par							
27.	<b>Total</b>		6,234,394			1,549,153		

\* 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: 01/01/04 To: 12/31/04

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)	\$ 773.68	\$ 470.17	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	2,054			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,589,139	\$	\$	\$
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)	\$ 1,589,139	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,499.80	34	\$ 50,993
9.	Coronary Care Unit	\$ 1,399.46	38	\$ 53,179
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 684.68	1,982	\$ 1,357,036
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,549,153
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 4,599,500</b>

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

<b>Medicare Provider Number:</b> 26-0091	<b>Public Aid Provider Number:</b> 19035
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/04 To: 12/31/04

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: 01/01/04 To: 12/31/04

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	319,247	105,660,619	0.003021	306,277			925		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	2,266,804	23,163,508	0.097861	146,549			14,341		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	458,962	9,933,681	0.046203	12,678			586		
8.	Laboratory	217,719	90,597,377	0.002403	777,704			1,869		
9.	Blood-Administration									
10.	Anatomic Pathology	37,297	9,152,700	0.004075	63,506			259		
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	269,086	14,877,635	0.018087	15,937			288		
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	40,838,638	0.000122	25,019			3		
23.02	Vascular Lab									
23.03	Endoscopy	13,800	17,575,306	0.000785	4,666			4		
23.04	Pharmacy-Intravenous DrugsTherap									
23.05	Sleep Disorder									
23.06	Psychotherapy	79,000	7,074,507	0.011167						
23.07	Clinical Nutrition									
23.08	Lab Stem Cell									
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic	87,203	10,298,442	0.008468						
25.	Emergency	4,017,099	56,510,212	0.071086						
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	106,775	64,556	1.65	2,054			3,389		
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit	50,899	3,066	16.60	34			564		
32.	Coronary Care Unit	50,841	3,668	13.86	38			527		
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							22,755		

\* 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: 01/01/04 To: 12/31/04

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)	4,599,500		
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)	22,755		
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>	4,622,255		
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)	6,234,394
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,273,189
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	84,175
	F. Coronary Care Unit	105,237
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	3,399,094
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	12,096,089
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	7,473,834
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: 01/01/04 To: 12/31/04

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)	4,622,255		
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)	4,622,255		
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>	4,622,255		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

**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)	7,473,834
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 (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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

**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**

<b>Medicare Provider Number:</b> 26-0091	<b>Public Aid Provider Number:</b> 19035
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/04 To: 12/31/04

**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	40,780,071	105,660,619	0.385953
2.	Recovery Room	2,317,070	8,127,919	0.285075
3.	Delivery and Labor Room	7,248,537	21,724,447	0.333658
4.	Anesthesiology	3,563,534	23,163,508	0.153843
5.	Radiology - Diagnostic	14,610,568	90,255,416	0.161880
6.	Radiology - Therapeutic	1,488,727	6,852,656	0.217248
7.	Nuclear Medicine	2,028,445	9,933,681	0.204199
8.	Laboratory	15,966,238	90,597,377	0.176233
9.	Blood-Administration	5,395,620	12,257,499	0.440189
10.	Anatomic Pathology	2,724,335	9,152,700	0.297654
11.	Intravenous Therapy	1,042,641	1,917,303	0.543806
12.	Respiratory Therapy	8,439,210	58,311,224	0.144727
13.	Physical Therapy	1,634,755	3,543,801	0.461300
14.	Occupational Therapy	496,653	1,582,035	0.313933
15.	Speech Pathology	1,012,703	2,425,187	0.417577
16.	EKG	2,203,413	14,877,635	0.148102
17.	EEG	754,921	1,288,352	0.585959
18.	Med. / Surg. Supplies	91,920	29,087	3.160175
19.	Drugs Charged to Patients	15,713,932	57,952,439	0.271152
20.	Renal Dialysis	1,909,869	7,013,066	0.272330
21.	Transport Services	1,806,091	1,392,337	1.297165
22.	Ultrasound	1,232,108	7,229,435	0.170429
23.	Pain Management	614,920	4,507,172	0.136431
23.01	Cardiac Catheterization	9,000,982	40,838,638	0.220404
23.02	Vascular Lab	1,017,422	9,972,952	0.102018
23.03	Endoscopy	3,534,171	17,575,306	0.201087
23.04	Pharmacy-Intravenous DrugsTherapy	9,048,314	41,798,235	0.216476
23.05	Sleep Disorder	221,761	721,803	0.307232
23.06	Psychotherapy	1,526,624	7,074,507	0.215792
23.07	Clinical Nutrition	1,281,897	207,922	6.165278
23.08	Lab Stem Cell	468,379	199,342	2.349625
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	12,519,097	10,298,442	1.215630
25.	Emergency	18,002,661	56,510,212	0.318574
26.	Observation Beds (Non-distinct Part)			
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	49,945,940	64,556	773.68
28.	Psychiatric Unit	4,697,509	9,991	470.17
29.				
30.				
31.	Intensive Care Unit	4,598,377	3,066	1,499.80
32.	Coronary Care Unit	5,133,203	3,668	1,399.46
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	10,072,944	14,712	684.68

**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: 01/01/04 To: 12/31/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,126		2,126
Newborn Days	1,982		1,982
Total Inpatient Revenue	12,096,089		12,096,089
Ancillary Revenue	6,234,394		6,234,394
Routine Revenue	5,861,695		5,861,695
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Determined that CCU Bed Days Available = 4,392. 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.

Included 4 Psych days and \$4,520 Psych charges with Adults and Peds as there was no psych report completed by the provider.