

# 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: 07-01-03	To: 06-30-04

## 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 07-01-03 and ending 06-30-04 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: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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	628	229,848		139,570	60.72%		37,318	4.77	
2.	Psych Center	54	19,764		15,927	80.59%		2,382	6.69	
3.	Rehab Center	49	17,934		12,473	69.55%		814	15.32	
4.										
5.	Intensive Care Unit	40	14,640		13,925	95.12%				
6.	Coronary Care Unit	16	5,856		3,833	65.45%				
7.	Neonatal Care Unit	57	20,862		20,696	99.20%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	91	33,306		16,480	49.48%				
16.	Total	935	342,210		222,904	65.14%		40,514	5.10	
17.	Observation Bed Days				5,504					

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psych Center									
3.	Rehab Center				124			7	17.71	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal Care Unit									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				124	0.06%		7	17.71	

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-Rehabilitation	Period Covered by Statement:	From: 07-01-03 To: 06-30-04

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	0.474860	14,265			6,774		
2.	Recovery Room	0.222315	854			190		
3.	Delivery and Labor Room	0.485648						
4.	Anesthesiology	0.245243	2,939			721		
5.	Radiology - Diagnostic	0.335645	1,899			637		
6.	Radiology - Therapeutic	0.329472						
7.	Radioisotope	0.204289						
8.	Laboratory	0.147729	18,255			2,697		
9.	Hyperbaric/ OP Wound							
10.	Blood - Administration	0.449167	2,915			1,309		
11.	Pain Therapy Center							
12.	Respiratory Therapy	0.215408	27,335			5,888		
13.	Physical Therapy	0.396696	107,989			42,839		
14.	Ambulatory Care Unit	0.395063						
15.								
16.	EKG	0.215537	2,172			468		
17.	EEG							
18.	Med. / Surg. Supplies	0.112224	37,658			4,226		
19.	Drugs Charged to Patients	0.287209	74,851			21,498		
20.	Renal Dialysis	0.294321						
21.	Ambulance	3.057729						
22.	Ultrasound	0.134898	826			111		
23.	CT Scan	0.070266						
23.01	Magnetic Resonance Imaging	0.157794	2,250			355		
23.02	Oncology							
23.03	Laboratory- Pathological	0.520924						
23.04	ASC (Non-distinct Part)	0.273982	405			111		
23.05	Cardiac Catheterization Laboratory	0.315699						
23.06	Gastrointestinal Services	0.176141						
23.07	Electroconvulsive Therapy	0.283088						
23.08	O/P Psych							
23.09	Natural Family Planning							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	5.880202						
25.	Emergency	0.356117						
26.	Observation Beds (Non-distinct Part)	0.642593						
27.	<b>Total</b>		294,613			87,824		

\* 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-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	\$ 636.79	\$ 512.11	\$ 515.61	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			124	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 63,936	\$
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)	\$	\$	\$ 63,936	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,030.55		\$
9.	Coronary Care Unit	\$ 2,359.23		\$
10.	Neonatal Care Unit	\$ 719.55		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 360.07		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 87,824
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 151,760</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-Rehabilitation	<b>Period Covered by Statement:</b> From: 07-01-03 To: 06-30-04

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.	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: <b>26-0020</b>	Public Aid Provider Number: <b>19029</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>07-01-03</b> To: <b>06-30-04</b>

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
	<b>Inpatient Ancillary Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>		<b>(6)</b>	<b>(7)</b>	
1.	Operating Room	671,978	126,585,773	0.005308	14,265			76		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	16,900	50,653,750	0.000334	1,899			1		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	227,514	110,218,023	0.002064	18,255			38		
9.	Hyperbaric/ OP Wound									
10.	Blood - Administration	29,164	17,392,883	0.001677	2,915			5		
11.	Pain Therapy Center	12,195		#DIV/0!						
12.	Respiratory Therapy									
13.	Physical Therapy	230,943	32,247,863	0.007161	107,989			773		
14.	Ambulatory Care Unit									
15.										
16.	EKG	3,946,864	76,840,270	0.051365	2,172			112		
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)	44,424	13,572,991	0.003273	405			1		
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	66,724	980,798	0.068030						
25.	Emergency	4,299,200	46,601,904	0.092254						
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	1,074,172	145,074	7.40						
28.	Psych Center	120,328	15,927	7.55						
29.	Rehab Center									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	956,997	3,833	249.67						
33.	Neonatal Care Unit	233,088	20,696	11.26						
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							1,006		

\* 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-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	151,760		
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)	1,006		
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>	152,766		
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)	294,613
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psych Center	
	C. Rehab Center	81,536
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal Care Unit	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	212
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	376,361
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	223,595
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-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	152,766		
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)	152,766		
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>	152,766		

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-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

**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)	223,595
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-Rehabilitation	Period Covered by Statement: From: 07-01-03 To: 06-30-04

**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 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-Rehabilitation	<b>Period Covered by Statement:</b> From: 07-01-03	<b>To:</b> 06-30-04

**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	60,110,579	126,585,773	0.474860
2.	Recovery Room	3,244,147	14,592,542	0.222315
3.	Delivery and Labor Room	11,494,514	23,668,418	0.485648
4.	Anesthesiology	6,029,365	24,585,234	0.245243
5.	Radiology - Diagnostic	17,001,659	50,653,750	0.335645
6.	Radiology - Therapeutic	5,149,392	15,629,238	0.329472
7.	Radioisotope	3,970,354	19,434,974	0.204289
8.	Laboratory	16,282,366	110,218,023	0.147729
9.	Hyperbaric/ OP Wound			
10.	Blood - Administration	7,812,308	17,392,883	0.449167
11.	Pain Therapy Center			
12.	Respiratory Therapy	9,317,334	43,254,283	0.215408
13.	Physical Therapy	12,792,611	32,247,863	0.396696
14.	Ambulatory Care Unit	1,833,798	4,641,789	0.395063
15.				
16.	EKG	16,561,949	76,840,270	0.215537
17.	EEG			
18.	Med. / Surg. Supplies	4,900,131	43,663,789	0.112224
19.	Drugs Charged to Patients	32,120,423	111,836,322	0.287209
20.	Renal Dialysis	1,640,010	5,572,178	0.294321
21.	Ambulance	92,215	30,158	3.057729
22.	Ultrasound	1,035,403	7,675,470	0.134898
23.	CT Scan	3,636,288	51,749,993	0.070266
23.01	Magnetic Resonance Imaging	3,342,914	21,185,254	0.157794
23.02	Oncology			
23.03	Laboratory- Pathological	3,077,711	5,908,172	0.520924
23.04	ASC (Non-distinct Part)	3,718,749	13,572,991	0.273982
23.05	Cardiac Catheterization Laboratory	12,352,124	39,126,272	0.315699
23.06	Gastrointestinal Services	5,152,026	29,249,483	0.176141
23.07	Electroconvulsive Therapy	459,822	1,624,305	0.283088
23.08	O/P Psych			
23.09	Natural Family Planning			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	5,767,290	980,798	5.880202
25.	Emergency	16,595,752	46,601,904	0.356117
26.	Observation Beds (Non-distinct Part)	3,233,215	5,031,513	0.642593
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	92,382,312	145,074	636.79
28.	Psych Center	8,156,346	15,927	512.11
29.	Rehab Center	6,431,164	12,473	515.61
30.				
31.	Intensive Care Unit	14,350,423	13,925	1,030.55
32.	Coronary Care Unit	9,042,922	3,833	2,359.23
33.	Neonatal Care Unit	14,891,724	20,696	719.55
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	5,933,888	16,480	360.07

