

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: 01/01/05	To: 12/31/05	

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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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 01/01/05 and ending 12/31/05 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: 01/01/05 To: 12/31/05

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	372	135,780		65,654	48.35%		17,868	4.06	
2.	Psychiatric Unit	38	13,870		9,746	70.27%		1,197	8.14	
3.										
4.										
5.	Intensive Care Unit	12	4,380		3,205	73.17%				
6.	Coronary Care Unit	12	4,380		3,758	85.80%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	48	17,520		15,112	86.26%				
16.	Total	482	175,930		97,475	55.41%		19,065	4.32	
17.	Observation Bed Days				3,161					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,331			300	4.58	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				20					
6.	Coronary Care Unit				24					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				2,285					
16.	Total				3,660	3.75%		300	4.58	

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: 01/01/05 To: 12/31/05

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room	0.402847	246,556			99,324		
2.	Recovery Room	0.311430	17,859			5,562		
3.	Delivery and Labor Room	0.350940	2,060,502			723,113		
4.	Anesthesiology	0.153996	173,280			26,684		
5.	Radiology - Diagnostic	0.163908	174,410			28,587		
6.	Radiology - Therapeutic	0.261434	13,836			3,617		
7.	Nuclear Medicine	0.189510	18,687			3,541		
8.	Laboratory	0.167527	866,821			145,216		
9.	Blood-Administration	0.394544	76,623			30,231		
10.	Anatomic Pathology	0.305788	259,958			79,492		
11.	Intravenous Therapy	0.833107	5,545			4,620		
12.	Respiratory Therapy	0.136813	792,868			108,475		
13.	Physical Therapy	0.477586	5,384			2,571		
14.	Occupational Therapy	0.290327						
15.	Speech Pathology	0.313932						
16.	EKG	0.140492	9,776			1,373		
17.	EEG	0.440031						
18.	Med. / Surg. Supplies	4.675593						
19.	Drugs Charged to Patients	0.215643	363,874			78,467		
20.	Renal Dialysis	0.268381	21,761			5,840		
21.	Transport Services	1.342283						
22.	Ultrasound	0.178235	44,643			7,957		
23.	Pain Management	0.124839						
23.01	Cardiac Catheterization	0.263990	200,019			52,803		
23.02	Vascular Lab	0.087565	96,987			8,493		
23.03	Endoscopy	0.217532	12,607			2,742		
23.04	Pharmacy-Intravenous DrugsThera	0.281391	624,549			175,742		
23.05	Sleep Disorder	0.343546						
23.06	Psychotherapy	0.216734						
23.07	Clinical Nutrition	4.192111	96			402		
23.08	Lab Stem Cell	5.816016						
23.09								
Outpatient Service Cost Centers								
24.	Clinic	1.290907						
25.	Emergency	0.319960						
26.	Observation Beds (Non-distinct Par	0.394598						
27.	Total		6,086,641			1,594,852		

* 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: 01/01/05 To: 12/31/05

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)	\$ 792.32	\$ 514.79	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,331			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,054,578	\$	\$	\$
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)	\$ 1,054,578	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,627.50	20	\$ 32,550
9.	Coronary Care Unit	\$ 1,443.84	24	\$ 34,652
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 709.89	2,285	\$ 1,622,099
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,594,852
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 4,338,731

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: 01/01/05 To: 12/31/05

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: 01/01/05 To: 12/31/05

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	201,957	114,786,312	0.001759	246,556			434		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	3,482,504	24,970,313	0.139466	173,280			24,167		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	379,643	10,797,941	0.035159	18,687			657		
8.	Laboratory	153,511	99,351,861	0.001545	866,821			1,339		
9.	Blood-Administration									
10.	Anatomic Pathology	41,665	9,416,457	0.004425	259,958			1,150		
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	285,951	17,146,091	0.016677	9,776			163		
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	45,259	56,653,852	0.000799	200,019			160		
23.02	Vascular Lab									
23.03	Endoscopy	20,550	19,962,079	0.001029	12,607			13		
23.04	Pharmacy-Intravenous DrugsTherap									
23.05	Sleep Disorder									
23.06	Psychotherapy	84,000	7,398,808	0.011353						
23.07	Clinical Nutrition									
23.08	Lab Stem Cell									
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic	114,499	11,554,712	0.009909						
25.	Emergency	3,354,202	63,688,126	0.052666						
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	49,576	68,815	0.72	1,331			958		
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit	42,635	3,205	13.30	20			266		
32.	Coronary Care Unit	42,589	3,758	11.33	24			272		
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							29,579		

* 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: 01/01/05 To: 12/31/05

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)	4,338,731		
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)	29,579		
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)	4,368,310		
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)	6,086,641
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,018,667
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	62,645
	F. Coronary Care Unit	71,074
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	4,098,503
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	12,337,530
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	7,969,220
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: 01/01/05 To: 12/31/05

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)	4,368,310		
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)	4,368,310		
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)	4,368,310		

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: 01/01/05 To: 12/31/05

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)	7,969,220
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: 01/01/05 To: 12/31/05

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, 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

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	46,241,320	114,786,312	0.402847
2.	Recovery Room	2,704,361	8,683,693	0.311430
3.	Delivery and Labor Room	8,004,006	22,807,345	0.350940
4.	Anesthesiology	3,845,321	24,970,313	0.153996
5.	Radiology - Diagnostic	16,199,743	98,834,094	0.163908
6.	Radiology - Therapeutic	1,653,684	6,325,433	0.261434
7.	Nuclear Medicine	2,046,314	10,797,941	0.189510
8.	Laboratory	16,644,096	99,351,861	0.167527
9.	Blood-Administration	5,501,360	13,943,586	0.394544
10.	Anatomic Pathology	2,879,441	9,416,457	0.305788
11.	Intravenous Therapy	1,164,394	1,397,653	0.833107
12.	Respiratory Therapy	7,787,307	56,919,218	0.136813
13.	Physical Therapy	1,885,693	3,948,386	0.477586
14.	Occupational Therapy	459,574	1,582,954	0.290327
15.	Speech Pathology	924,215	2,944,002	0.313932
16.	EKG	2,408,881	17,146,091	0.140492
17.	EEG	657,521	1,494,262	0.440031
18.	Med. / Surg. Supplies	90,613	19,380	4.675593
19.	Drugs Charged to Patients	13,682,182	63,448,446	0.215643
20.	Renal Dialysis	2,090,892	7,790,756	0.268381
21.	Transport Services	2,146,622	1,599,232	1.342283
22.	Ultrasound	1,437,659	8,066,100	0.178235
23.	Pain Management	699,825	5,605,799	0.124839
23.01	Cardiac Catheterization	14,956,033	56,653,852	0.263990
23.02	Vascular Lab	1,046,136	11,946,975	0.087565
23.03	Endoscopy	4,342,381	19,962,079	0.217532
23.04	Pharmacy-Intravenous DrugsTherapy	11,683,008	41,518,698	0.281391
23.05	Sleep Disorder	290,061	844,316	0.343546
23.06	Psychotherapy	1,603,575	7,398,808	0.216734
23.07	Clinical Nutrition	1,017,635	242,750	4.192111
23.08	Lab Stem Cell	364,670	62,701	5.816016
23.09				
Outpatient Ancillary Centers				
24.	Clinic	14,916,059	11,554,712	1.290907
25.	Emergency	20,377,670	63,688,126	0.319960
26.	Observation Beds (Non-distinct Part)	3,055,880	7,744,284	0.394598
Routine Service Cost Centers				
27.	Adults and Pediatrics	54,523,400	68,815	792.32
28.	Psychiatric Unit	5,017,156	9,746	514.79
29.				
30.				
31.	Intensive Care Unit	5,216,136	3,205	1,627.50
32.	Coronary Care Unit	5,425,943	3,758	1,443.84
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	10,727,923	15,112	709.89

**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: 01/01/05 To: 12/31/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,375		1,375
Newborn Days	2,285		2,285
Total Inpatient Revenue	12,337,530		12,337,530
Ancillary Revenue	6,086,641		6,086,641
Routine Revenue	6,250,889		6,250,889
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:

Filed OHF Supplement No. 2 charges for Radiology-Diagnostic, Nuclear Medicine, Laboratory, Anatomic Pathology, Speech 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.

Determined Blood Administration charges to be Anatomic Pathology.

Determined Blood charges to be Blood Administration.

Removed \$280 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.

Determined Nursery Bed Days using prior year amounts.