

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: 07-01-04	To: 06-30-05

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 07-01-04 and ending 06-30-05 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: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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	628	229,220		136,287	59.46%		35,651	4.97	
2.	Psych Center	54	19,710		15,601	79.15%		2,566	6.08	
3.	Rehab Center	49	17,885		13,392	74.88%		856	15.64	
4.										
5.	Intensive Care Unit	40	14,600		14,145	96.88%				
6.	Coronary Care Unit	16	5,840		3,466	59.35%				
7.	Neonatal Care Unit	65	23,725		23,416	98.70%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	83	30,295		17,228	56.87%				
16.	Total	935	341,275		223,535	65.50%		39,073	5.28	
17.	Observation Bed Days				7,557					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psych Center									
3.	Rehab Center				106			4	26.50	
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				106	0.05%		4	26.50	

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: 07-01-04 To: 06-30-05

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	0.487511						
2.	Recovery Room	0.172572						
3.	Delivery and Labor Room	0.539553						
4.	Anesthesiology	0.235522						
5.	Radiology - Diagnostic	0.305955	14,143			4,327		
6.	Radiology - Therapeutic	0.291132	56			16		
7.	Radioisotope	0.174339						
8.	Laboratory	0.135770	21,050			2,858		
9.	Hyperbaric/ OP Wound							
10.	Blood - Administration	0.433298						
11.	Pain Therapy Center							
12.	Respiratory Therapy	0.210913	4,365			921		
13.	Physical Therapy	0.408269	64,734			26,429		
14.	Ambulatory Care Unit	0.318137						
15.								
16.	EKG	0.223425	4,976			1,112		
17.	EEG							
18.	Med. / Surg. Supplies	0.115687	20,447			2,365		
19.	Drugs Charged to Patients	0.300735	33,125			9,962		
20.	Renal Dialysis	0.248222						
21.	Ambulance	2.939801						
22.	Ultrasound	0.123822	1,239			153		
23.	CT Scan	0.052275	3,721			195		
23.01	Magnetic Resonance Imaging	0.130046						
23.02	Oncology	0.518729						
23.03	Laboratory- Pathological	0.328022						
23.04	ASC (Non-distinct Part)	0.322890						
23.05	Cardiac Catheterization Laboratory	0.288236						
23.06	Gastrointestinal Services	0.175873						
23.07	Electroconvulsive Therapy	0.269723						
23.08	O/P Psych	0.701131						
23.09	Natural Family Planning							
Outpatient Service Cost Centers								
24.	Clinic	6.619564						
25.	Emergency	0.332760						
26.	Observation Beds (Non-distinct Part)	0.777258						
27.	Total		167,856			48,338		

* 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: 07-01-04 To: 06-30-05

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)	\$ 713.67	\$ 550.25	\$ 560.46	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			106	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 59,409	\$
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)	\$	\$	\$ 59,409	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,131.67		\$
9.	Coronary Care Unit	\$ 2,445.63		\$
10.	Neonatal Care Unit	\$ 825.14		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 399.15		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 48,338
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 107,747

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

Medicare Provider Number: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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.	Psych Center						
4.	Rehab Center						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal Care Unit						
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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	1,779,046	141,036,349	0.012614						
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	8,600	60,098,569	0.000143	14,143			2		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	240,813	125,594,252	0.001917	21,050			40		
9.	Hyperbaric/ OP Wound									
10.	Blood - Administration	29,164	18,739,585	0.001556						
11.	Pain Therapy Center									
12.	Respiratory Therapy									
13.	Physical Therapy	55,045	36,193,013	0.001521	64,734			98		
14.	Ambulatory Care Unit									
15.										
16.	EKG	3,645,696	91,984,223	0.039634	4,976			197		
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)	47,925	13,176,463	0.003637						
23.05	Cardiac Catheterization Laboratory									
23.06	Gastrointestinal Services									
23.07	Electroconvulsive Therapy									
23.08	O/P Psych									
23.09	Natural Family Planning									
Outpatient Ancillary Cost Centers										
24.	Clinic	62,125	1,058,328	0.058701						
25.	Emergency	4,455,937	59,139,749	0.075346						
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	2,122,360	143,844	14.75						
28.	Psych Center	44,277	15,601	2.84						
29.	Rehab Center									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	926,864	3,466	267.42						
33.	Neonatal Care Unit	250,000	23,416	10.68						
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							337		

* 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: 07-01-04 To: 06-30-05

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)	107,747		
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)	337		
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)	108,084		
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)	167,856
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psych Center	
	C. Rehab Center	95,493
	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)	213
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	263,562
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	155,478
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: 07-01-04 To: 06-30-05

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)	108,084		
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)	108,084		
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)	108,084		

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: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)	155,478
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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
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: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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 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

Medicare Provider Number: 26-0020	Public Aid Provider Number: 19029
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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	68,756,743	141,036,349	0.487511
2.	Recovery Room	3,580,510	20,747,962	0.172572
3.	Delivery and Labor Room	14,254,982	26,419,984	0.539553
4.	Anesthesiology	6,467,141	27,458,725	0.235522
5.	Radiology - Diagnostic	18,387,440	60,098,569	0.305955
6.	Radiology - Therapeutic	5,784,165	19,867,876	0.291132
7.	Radioisotope	4,163,345	23,880,722	0.174339
8.	Laboratory	17,051,911	125,594,252	0.135770
9.	Hyperbaric/ OP Wound			
10.	Blood - Administration	8,119,828	18,739,585	0.433298
11.	Pain Therapy Center			
12.	Respiratory Therapy	10,490,445	49,738,181	0.210913
13.	Physical Therapy	14,776,479	36,193,013	0.408269
14.	Ambulatory Care Unit	1,951,164	6,133,087	0.318137
15.				
16.	EKG	20,551,595	91,984,223	0.223425
17.	EEG			
18.	Med. / Surg. Supplies	5,375,274	46,464,120	0.115687
19.	Drugs Charged to Patients	38,160,079	126,889,466	0.300735
20.	Renal Dialysis	1,861,652	7,499,936	0.248222
21.	Ambulance	61,483	20,914	2.939801
22.	Ultrasound	1,063,110	8,585,824	0.123822
23.	CT Scan	3,669,197	70,190,044	0.052275
23.01	Magnetic Resonance Imaging	3,384,642	26,026,582	0.130046
23.02	Oncology	1,254,658	2,418,718	0.518729
23.03	Laboratory- Pathological	3,172,015	9,670,123	0.328022
23.04	ASC (Non-distinct Part)	4,254,543	13,176,463	0.322890
23.05	Cardiac Catheterization Laboratory	15,888,703	55,123,910	0.288236
23.06	Gastrointestinal Services	5,103,240	29,016,683	0.175873
23.07	Electroconvulsive Therapy	508,567	1,885,513	0.269723
23.08	O/P Psych	1,035,903	1,477,475	0.701131
23.09	Natural Family Planning			
Outpatient Ancillary Centers				
24.	Clinic	7,005,670	1,058,328	6.619564
25.	Emergency	19,679,354	59,139,749	0.332760
26.	Observation Beds (Non-distinct Part)	4,956,939	6,377,470	0.777258
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	102,656,880	143,844	713.67
28.	Psych Center	8,584,447	15,601	550.25
29.	Rehab Center	7,505,654	13,392	560.46
30.				
31.	Intensive Care Unit	16,007,498	14,145	1,131.67
32.	Coronary Care Unit	8,476,566	3,466	2,445.63
33.	Neonatal Care Unit	19,321,540	23,416	825.14
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	6,876,634	17,228	399.15

