

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

## 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 type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Rehabilitation	<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 07-01-05 and ending 06-30-06 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-Rehab	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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	624	227,760		137,619	60.42%		35,810	4.98	
2.	Psych Center	54	19,710		15,327	77.76%		2,341	6.55	
3.	Rehab Center	49	17,885		13,385	74.84%		881	15.19	
4.										
5.	Intensive Care Unit	44	16,060		15,581	97.02%				
6.	Coronary Care Unit	16	5,840		2,299	39.37%				
7.	Neonatal Care Unit	65	23,725		22,761	95.94%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	83	30,295		18,296	60.39%				
16.	Total	935	341,275		225,268	66.01%		39,032	5.30	
17.	Observation Bed Days				6,557					

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psych Center									
3.	Rehab Center				155			9	17.22	
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				155	0.07%		9	17.22	

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-Rehab	Period Covered by Statement:	From: 07-01-05 To: 06-30-06

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	0.471471	6,613			3,118		
2.	Recovery Room	0.146940	1,606			236		
3.	Delivery and Labor Room	0.445596						
4.	Anesthesiology	0.203711	1,875			382		
5.	Radiology - Diagnostic	0.273420	4,448			1,216		
6.	Radiology - Therapeutic	0.254869	1,104			281		
7.	Radioisotope	0.153867						
8.	Laboratory	0.109499	28,836			3,158		
9.	Hyperbaric/ OP Wound							
10.	Blood - Administration	0.419230						
11.	Pain Therapy Center							
12.	Respiratory Therapy	0.201011	1,679			337		
13.	Physical Therapy	0.397630	98,408			39,130		
14.	Ambulatory Care Unit	0.070015						
15.								
16.	EKG	0.177805	8,994			1,599		
17.	EEG							
18.	Med. / Surg. Supplies	0.124156	10,989			1,364		
19.	Drugs Charged to Patients	0.287401	34,037			9,782		
20.	Renal Dialysis	0.217500						
21.	Ambulance	1.949412						
22.	Ultrasound	0.212058	1,062			225		
23.	CT Scan	0.041043	5,705			234		
23.01	Magnetic Resonance Imaging	0.105535	9,009			951		
23.02	Oncology	0.391454						
23.03	Laboratory- Pathological	0.219252	565			124		
23.04	ASC (Non-distinct Part)	0.289644	280			81		
23.05	Cardiac Catheterization Laboratory	0.288764						
23.06	Gastrointestinal Services	0.165376	1,641			271		
23.07	Electroconvulsive Therapy	0.303404						
23.08	O/P Psych	0.731292						
23.09	Natural Family Planning							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	6.304098						
25.	Emergency	0.283110						
26.	Observation Beds (Non-distinct Part)	0.512939						
27.	<b>Total</b>		216,851			62,489		

\* 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-Rehab	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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)	\$ 731.45	\$ 589.50	\$ 539.11	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			155	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 83,562	\$
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)	\$	\$	\$ 83,562	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,167.09		\$
9.	Coronary Care Unit	\$ 3,292.74		\$
10.	Neonatal Care Unit	\$ 809.68		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 465.16		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 62,489
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 146,051</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-Rehab	<b>Period Covered by Statement:</b> From: 07-01-05 To: 06-30-06

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-Rehab</b>	Period Covered by Statement: From: <b>07-01-05</b> To: <b>06-30-06</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
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room	1,009,980	155,125,539	0.006511	6,613			43		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	8,330	74,143,937	0.000112	4,448					
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	216,104	151,653,363	0.001425	28,836			41		
9.	Hyperbaric/ OP Wound									
10.	Blood - Administration	29,164	20,114,063	0.001450						
11.	Pain Therapy Center									
12.	Respiratory Therapy	10,694	57,108,152	0.000187	1,679					
13.	Physical Therapy	81,966	40,162,716	0.002041	98,408			201		
14.	Ambulatory Care Unit									
15.										
16.	EKG	4,797,663	83,947,324	0.057151	8,994			514		
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)	64,800	13,268,728	0.004884	280			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	283,945	1,176,689	0.241308						
25.	Emergency	4,504,992	68,769,951	0.065508						
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	5,121,100	144,176	35.52						
28.	Psych Center	59,847	15,327	3.90						
29.	Rehab Center									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	628,374	2,299	273.32						
33.	Neonatal Care Unit	208,333	22,761	9.15						
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							800		

\* 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**

<b>Medicare Provider Number:</b> 26-0020	<b>Public Aid Provider Number:</b> 19029
<b>Program:</b> Medicaid-Rehab	<b>Period Covered by Statement:</b> From: 07-01-05 To: 06-30-06

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)	146,051		
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)	800		
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>	146,851		
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)	216,851
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psych Center	
	C. Rehab Center	119,941
	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)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	336,792
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	189,941
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-Rehab	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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)	146,851		
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)	146,851		
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>	146,851		

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-Rehab	Period Covered by Statement: From: 07-01-05 To: 06-30-06

**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)	189,941
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-Rehab	Period Covered by Statement: From: 07-01-05 To: 06-30-06

**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-Rehab	<b>Period Covered by Statement:</b> From: 07-01-05 To: 06-30-06

**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	73,137,172	155,125,539	0.471471
2.	Recovery Room	3,510,152	23,888,354	0.146940
3.	Delivery and Labor Room	14,195,994	31,858,449	0.445596
4.	Anesthesiology	6,033,242	29,616,684	0.203711
5.	Radiology - Diagnostic	20,272,443	74,143,937	0.273420
6.	Radiology - Therapeutic	6,006,344	23,566,413	0.254869
7.	Radioisotope	4,244,016	27,582,404	0.153867
8.	Laboratory	16,605,887	151,653,363	0.109499
9.	Hyperbaric/ OP Wound			
10.	Blood - Administration	8,432,414	20,114,063	0.419230
11.	Pain Therapy Center			
12.	Respiratory Therapy	11,479,373	57,108,152	0.201011
13.	Physical Therapy	15,969,907	40,162,716	0.397630
14.	Ambulatory Care Unit	429,406	6,133,087	0.070015
15.				
16.	EKG	14,926,290	83,947,324	0.177805
17.	EEG			
18.	Med. / Surg. Supplies	5,656,331	45,558,163	0.124156
19.	Drugs Charged to Patients	40,137,834	139,658,128	0.287401
20.	Renal Dialysis	1,835,647	8,439,741	0.217500
21.	Ambulance	40,770	20,914	1.949412
22.	Ultrasound	4,955,746	23,369,798	0.212058
23.	CT Scan	3,472,733	84,612,175	0.041043
23.01	Magnetic Resonance Imaging	3,169,023	30,028,299	0.105535
23.02	Oncology	1,412,148	3,607,439	0.391454
23.03	Laboratory- Pathological	2,990,047	13,637,465	0.219252
23.04	ASC (Non-distinct Part)	3,843,212	13,268,728	0.289644
23.05	Cardiac Catheterization Laboratory	16,871,381	58,426,119	0.288764
23.06	Gastrointestinal Services	5,343,737	32,312,576	0.165376
23.07	Electroconvulsive Therapy	533,689	1,759,005	0.303404
23.08	O/P Psych	1,027,641	1,405,240	0.731292
23.09	Natural Family Planning	369,738		
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	7,417,963	1,176,689	6.304098
25.	Emergency	19,469,486	68,769,951	0.283110
26.	Observation Beds (Non-distinct Part)	4,349,848	8,480,252	0.512939
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	105,457,799	144,176	731.45
28.	Psych Center	9,035,216	15,327	589.50
29.	Rehab Center	7,215,985	13,385	539.11
30.				
31.	Intensive Care Unit	18,184,435	15,581	1,167.09
32.	Coronary Care Unit	7,570,006	2,299	3,292.74
33.	Neonatal Care Unit	18,429,110	22,761	809.68
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	8,510,535	18,296	465.16

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

PRELIMINARY

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

<b>Inpatient Reconciliation</b>	<b>Provider's Records</b>	<b>Adjustments</b>	<b>Audited Cost Report</b>
Adult Days	155		155
Newborn Days			
Total Inpatient Revenue	336,792		336,792
Ancillary Revenue	216,851		216,851
Routine Revenue	119,941		119,941
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:**

Included \$20,044 in Adults & Ped charges in Sub II-Rehab charges on OHF Pg 7.

Adjusted filed Professional Component charges to match covered charges on W/S A-8-2.