

# 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: Union Hospital, Inc.		Medicare Provider Number: 15-0023	
Street: 1606 North 7th Street		Public Aid Provider Number: 20003	
City: Terre Haute	State: Indiana	Zip: 47804	
Period Covered by Statement:	From: 09-01-01	To: 08-31-02	

## 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	<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 checked="" type="checkbox"/> Medicaid Hospital	<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)) Union Hospital, Inc. 20003 for the cost report beginning 09-01-01 and ending 08-31-02 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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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	196	71,114	4,999	45,109	63.43%		11,363	4.81	
2.	Medical Rehab	12	4,380		3,586	81.87%		276	12.99	
3.										
4.										
5.	Intensive Care Unit	32	11,680		7,692	65.86%				
6.	Coronary Care Unit									
7.	Intensive Nursery	9	3,285		1,859	56.59%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	32	11,680		2,354	20.15%				
16.	Total	281	102,139	4,999	60,600	59.33%		11,639	5.00	
17.	Observation Bed Days				6,700					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			128	655			213	5.12	
2.	Medical Rehab									
3.										
4.										
5.	Intensive Care Unit				99					
6.	Coronary Care Unit									
7.	Intensive Nursery				336					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				67					
16.	Total			128	1,157	1.91%		213	5.12	

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:	15-0023	Public Aid Provider Number:	20003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09-01-01 To: 08-31-02

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 & WVSC	0.309727	260,812			80,781		
2.	Recovery Room	0.549680	41,456			22,788		
3.	Delivery and Labor Room	0.604015	200,702			121,227		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.681410	40,681			27,720		
6.	Radiology - Therapeutic	0.375924	10,862			4,083		
7.	Radioisotope	0.445281	3,622			1,613		
8.	Laboratory	0.155980	256,951			40,079		
9.	Blood							
10.	Blood - Administration	0.819581	17,230			14,121		
11.	Intravenous Therapy	0.090861	171,426			15,576		
12.	Respiratory Therapy	0.501065	30,610			15,338		
13.	Physical/ OP Physical Therapy	0.615912	6,925			4,265		
14.	Occupational Therapy	0.461343	5,660			2,611		
15.	Speech Pathology	0.528255	8,478			4,479		
16.	EKG	0.201787	35,420			7,147		
17.	EEG	0.242193	3,347			811		
18.	Med. / Surg. Supplies	0.105659	330,495			34,920		
19.	Drugs Charged to Patients	0.238504	554,078			132,150		
20.	Renal Acute/ Renal CAPD	0.611997	2,652			1,623		
21.	Ambulance							
22.	Cardiac Surgery (Open Heart Surge	0.345905	41,140			14,231		
23.	O/P Treatment Room	0.462055						
23.01	CT Scan	0.190646	45,391			8,654		
23.02	Cardiac Catheterization Laboratory	0.407964	109,211			44,554		
23.03	Psychiatric/ Psychological Services	0.724940	447			324		
23.04	MHC/Family/Phys Prac/Rrl Hlth/Pai	1.635478						
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.427261	29,322			12,528		
26.	Observ. Bds (Non-distinct/ Treat. R	0.631851	53,095			33,548		
27.	<b>Total</b>		2,260,013			645,171		

\* 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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I Medical Rehab	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 378.24	\$ 555.82	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	655			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 247,747	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 1,381.68	\$	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)	128			
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$ 176,855	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 424,602	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,020.92	99	\$ 101,071
9.	Coronary Care Unit	\$		\$
10.	Intensive Nursery	\$ 676.17	336	\$ 227,193
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 354.54	67	\$ 23,754
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 645,171
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 1,421,791</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> 15-0023		<b>Public Aid Provider Number:</b> 20003	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 09-01-01 To: 08-31-02	

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.	Medical Rehab						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Intensive Nursery						
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.	Observ. Bds (Non-distinct/ Treat.										
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:	15-0023	Public Aid Provider Number:	20003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09-01-01 To: 08-31-02

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 & WVSC	3,236,184	62,887,521	0.051460	260,812			13,421		
2.	Recovery Room									
3.	Delivery and Labor Room	10,400	4,057,177	0.002563	200,702			514		
4.	Anesthesiology									
5.	Radiology - Diagnostic	3,651,948	11,866,345	0.307757	40,681			12,520		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical/ OP Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	54,880	5,703,050	0.009623	35,420			341		
17.	EEG	144,757	1,347,836	0.107400	3,347			359		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Acute/ Renal CAPD									
21.	Ambulance									
22.	Cardiac Surgery (Open Heart Surger	203,685	5,954,247	0.034208	41,140			1,407		
23.	O/P Treatment Room									
23.01	CT Scan									
23.02	Cardiac Catheterization Laboratory	231,200	23,550,064	0.009817	109,211			1,072		
23.03	Psychiatric/ Psychological Services									
23.04	MHC/Family/Phys Prac/Rrl Hlth/Pain	1,858,304	7,723,814	0.240594						
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency									
26.	Observ. Bds (Non-distinct/ Treat. Rm)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.	Medical Rehab									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Intensive Nursery									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							29,634		

\* 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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)	1,421,791		
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)	29,634		
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>	1,451,425		
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)	2,260,013
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	386,625
	B. Medical Rehab	
	C.	
	D.	
	E. Intensive Care Unit	120,285
	F. Coronary Care Unit	
	G. Intensive Nursery	217,950
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	76,895
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	3,061,768
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,610,343
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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)	1,451,425		
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)	1,451,425		
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>	1,451,425		

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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

**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)	1,610,343
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.	<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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

**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 Medical Rehab	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 Medical Rehab	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 Medical Rehab	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)	37,122,105			
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	24,799,365			
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	12,322,740			
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	46,810			
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	4,999			
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	2,465.04			
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	529.79			
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	1,935.25			
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))	1,381.68			
7. Private room cost differential adjustment (Line 2B X Line 6)	6,907,018			
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)	19,596,386			
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)	378.24			

**Hospital Statement of Cost  
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

**PRELIMINARY**

<b>Medicare Provider Number:</b> 15-0023	<b>Public Aid Provider Number:</b> 20003
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 09-01-01 To: 08-31-02

**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 & WVSC	19,477,951	62,887,521	0.309727
2.	Recovery Room	2,837,051	5,161,282	0.549680
3.	Delivery and Labor Room	2,450,594	4,057,177	0.604015
4.	Anesthesiology			
5.	Radiology - Diagnostic	8,085,846	11,866,345	0.681410
6.	Radiology - Therapeutic	3,005,086	7,993,859	0.375924
7.	Radioisotope	1,675,070	3,761,827	0.445281
8.	Laboratory	3,859,507	24,743,618	0.155980
9.	Blood			
10.	Blood - Administration	1,427,575	1,741,835	0.819581
11.	Intravenous Therapy	1,220,855	13,436,540	0.090861
12.	Respiratory Therapy	2,614,418	5,217,723	0.501065
13.	Physical/ OP Physical Therapy	2,992,459	4,858,579	0.615912
14.	Occupational Therapy	1,032,762	2,238,597	0.461343
15.	Speech Pathology	542,961	1,027,838	0.528255
16.	EKG	1,150,804	5,703,050	0.201787
17.	EEG	326,436	1,347,836	0.242193
18.	Med. / Surg. Supplies	1,659,214	15,703,529	0.105659
19.	Drugs Charged to Patients	10,803,025	45,295,026	0.238504
20.	Renal Acute/ Renal CAPD	532,430	869,988	0.611997
21.	Ambulance			
22.	Cardiac Surgery (Open Heart Surgery)	2,059,606	5,954,247	0.345905
23.	O/P Treatment Room	2,624,823	5,680,758	0.462055
23.01	CT Scan	1,866,942	9,792,716	0.190646
23.02	Cardiac Catheterization Laboratory	9,607,573	23,550,064	0.407964
23.03	Psychiatric/ Psychological Services	477,212	658,278	0.724940
23.04	MHC/Family/Phys Prac/Rrl Hlth/PainClin	12,632,128	7,723,814	1.635478
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	4,087,693	9,567,198	0.427261
26.	Observ. Bds (Non-distinct/ Treat. Rms.	3,297,807	5,219,280	0.631851
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics			See Supplement 1
28.	Medical Rehab	1,993,181	3,586	555.82
29.				
30.				
31.	Intensive Care Unit	7,852,945	7,692	1,020.92
32.	Coronary Care Unit			
33.	Intensive Nursery	1,256,993	1,859	676.17
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	834,594	2,354	354.54

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

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,090		1,090
Newborn Days	67		67
Total Inpatient Revenue	3,063,022	(1,254)	3,061,768
Ancillary Revenue	2,261,267	(1,254)	2,260,013
Routine Revenue	801,755		801,755
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:**

Filed Medicaid days and filed Medicaid charges were taken from the filed Log 208/ Inpatient summary.

Prior to FYE 08-31-01, filed reports have no Illinois Medicaid utilization of Medical Rehab. The utilization of 16 days is included with A&P.  
[That is consistent with the FYE 08-31-01 PRELIM.]

Removed \$1,254 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.

No adjustment was made to the filed W/S C charges to prepare the filed OHF report.

Medicaid days and charges for Intensive Nursery and Nursery were taken from the filed OHF report. The sums of those days and charges match days and charges for Nursery in the Log 208 summary.

Total Private Room Days = 4,999 and Intensive Nursery utilization = 1,859 were taken from the filed OHF-2.