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: Mercy Hospital & Medical Center	**Medicare Provider Number:** 14-0158
Street: 2525 South Michigan Avenue	**Public Aid Provider Number:** 3042
City: Chicago **State:** Illinois	**Zip:** 60616-2477
Period Covered by Statement: **From:** 07-01-01	**To:** 06-30-02

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
[ ]	Church	[ ]	Individual	[ ]	State	[ ]	Township
[ ]	Corporation	[ ]	Partnership	[ ]	City	[ ]	Hospital District
[ ]	Other (Specify)	[XXXX]	Corporation	[ ]	County	[ ]	Other (Specify)

Type of Hospital

[XXXX]	General Short-Term	[ ]	Psychiatric	[ ]	Cancer
[ ]	General Long-Term	[ ]	Rehabilitation	[ ]	Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

[XXXX]	Medicaid Hospital	[ ]	Medicaid Sub II	[ ]	DHS - Office of Rehabilitation Services
[ ]	Medicaid Sub I	[ ]	Medicaid Sub III	[ ]	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)) Mercy Hospital & Medical Cer 3042 for the cost report beginning 07-01-01 and ending 06-30-02 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	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.

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Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occu-pancy (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	271	93,304		45,625	48.90%		15,979	3.49	
2.	Psychiatric Unit	29	10,585		6,343	59.92%		855	7.42	
3.	Rehabilitation Unit	24	8,760		4,386	50.07%		443	9.90	
4.										
5.	Intensive Care Unit	14	5,110		4,378	85.68%				
6.	Coronary Care Unit	16	5,840		3,235	55.39%				
7.	Nursery ICU/Special Care Nursery	10	3,650		2,489	68.19%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	20	7,300		3,653	50.04%				
16.	Total	384	134,549		70,109	52.11%		17,277	3.85	
17.	Observation Bed Days				525					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				12,890			6,386	2.49	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				635					
6.	Coronary Care Unit				491					
7.	Nursery ICU/Special Care Nursery				1,896					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				2,781					
16.	**Total**				18,693	26.66%		6,386	2.49	

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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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 Total Billed O/P Charges (Gross) for Health Care Program Patients	Referred O/P E/R Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	Referred O/P E/R O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.399861	1,606,078			642,208		
2.	Recovery Room	0.301044	185,873			55,956		
3.	Delivery and Labor Room	0.370123	6,511,297			2,409,981		
4.	Anesthesiology	0.126304	643,137			81,231		
5.	Radiology - Diagnostic	0.311551	1,820,497			567,178		
6.	Radiology - Therapeutic	0.223913	35,343			7,914		
7.	Nuclear Medicine	0.203001						
8.	Laboratory	0.301583	3,780,579			1,140,158		
9.	Peds. Practice	0.168841						
10.	Psych. Partial Hospitalization	0.305581						
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.224533	1,462,705			328,426		
13.	Physical Therapy	0.361447	79,440			28,713		
14.	Occupational Therapy	0.442670	16,432			7,274		
15.	Speech Pathology	0.747106	70,512			52,680		
16.	Mercy Rheumatology Center	0.491474						
17.	EEG	0.390164	26,257			10,245		
18.	Med. / Surg. Supplies	0.283582	2,163,630			613,567		
19.	Drugs Charged to Patients	0.242279	6,617,277			1,603,227		
20.	Renal Dialysis	0.424207	151,638			64,326		
21.	Ambulance							
22.	G.I. Lab	0.342811	153,068			52,473		
23.	MRI Center	0.092635						
23.01	Pulmonary Rehab	2.198643						
23.02	ASC (Non-distinct Part)	1.098607						
23.03	Urology Services	0.323854	2,160			700		
23.04	Industrial Nursing	0.359060						
23.05	Audiology	1.444822						
23.06	Electrodiagnosis [EMG]	0.113083	7,544			853		
23.07	Cardiovascular Labs	0.297983	1,617,964			482,126		
23.08	Mercy Eye Center	0.676662						
23.09	Wound Management	0.716818	44,505			31,902		
	Outpatient Service Cost Centers							
24.	Clinic	0.732852						
25.	Emergency	0.390861	1,223,753			478,317		
26.	Observation Beds (Non-distinct Par	0.468686						
27.	**Total**		28,219,689			8,659,455		

* 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.

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Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 626.96	$ 503.96	$ 325.06	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	12,890			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 8,081,514	$	$	$
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)	$ 8,081,514	$	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,314.42	635	$ 834,657
9.	Coronary Care Unit	$ 1,238.15	491	$ 607,932
10.	Nursery ICU/Special Care Nursery	$ 463.22	1,896	$ 878,265
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 389.23	2,781	$ 1,082,449
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 8,659,455
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			**$ 20,144,272**

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

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Nursery ICU/Special Care Nurse						
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
		(1)	(2)	(3)	(4)	(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)**										

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

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic	115,580	4,595,783	0.025149	35,343			889		
7.	Nuclear Medicine									
8.	Laboratory	4,846	31,426,561	0.000154	3,780,579			582		
9.	Peds. Practice									
10.	Psych. Partial Hospitalization									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	Mercy Rheumatology Center									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	G.I. Lab									
23.	MRI Center									
23.01	Pulmonary Rehab									
23.02	ASC (Non-distinct Part)									
23.03	Urology Services									
23.04	Industrial Nursing									
23.05	Audiology									
23.06	Electrodiagnosis [EMG]									
23.07	Cardiovascular Labs	569,613	23,923,533	0.023810	1,617,964			38,524		
23.08	Mercy Eye Center									
23.09	Wound Management									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	996,159	20,771,357	0.047958	1,223,753			58,689		
26.	Observation Beds (Non-distinct Part)									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	571,052	46,150	12.37	12,890			159,449		
28.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Nursery ICU/Special Care Nursery									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	609,597	3,653	166.88	2,781			464,093		
37.	**Total**							722,226		

* 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:	Public Aid Provider Number:
14-0158	3042
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07-01-01 To: 06-30-02

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	20,144,272		
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)	722,226		
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)**	20,866,498		
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)	28,219,689
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	20,162,580
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Nursery ICU/Special Care Nursery	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	48,382,269
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	27,515,771
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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	20,866,498		
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)	20,866,498		
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)**	20,866,498		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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)	27,515,771
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)	(4)	(5)
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)	(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 **OHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0158	**Public Aid Provider Number:** 3042
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 07-01-01 To: 06-30-02

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 Psychiatric Unit**	**Sub II Rehabilitation Ur**	**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 Rehabilitation Ur**	**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

	1. Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III**
	(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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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)
	Inpatient Ancillary Centers			
1.	Operating Room	12,925,799	32,325,769	0.399861
2.	Recovery Room	923,376	3,067,244	0.301044
3.	Delivery and Labor Room	4,151,873	11,217,552	0.370123
4.	Anesthesiology	808,827	6,403,828	0.126304
5.	Radiology - Diagnostic	9,451,803	30,337,943	0.311551
6.	Radiology - Therapeutic	1,029,054	4,595,783	0.223913
7.	Nuclear Medicine	713,016	3,512,381	0.203001
8.	Laboratory	9,477,725	31,426,561	0.301583
9.	Peds. Practice	33,227	196,795	0.168841
10.	Psych. Partial Hospitalization	223,386	731,021	0.305581
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,705,487	7,595,695	0.224533
13.	Physical Therapy	1,093,045	3,024,080	0.361447
14.	Occupational Therapy	1,086,857	2,455,231	0.442670
15.	Speech Pathology	134,943	180,621	0.747106
16.	Mercy Rheumatology Center	78,080	158,869	0.491474
17.	EEG	128,589	329,577	0.390164
18.	Med. / Surg. Supplies	1,631,193	5,752,107	0.283582
19.	Drugs Charged to Patients	9,389,339	38,754,188	0.242279
20.	Renal Dialysis	826,240	1,947,729	0.424207
21.	Ambulance			
22.	G.I. Lab	1,169,087	3,410,301	0.342811
23.	MRI Center	518,721	5,599,597	0.092635
23.01	Pulmonary Rehab	714,115	324,798	2.198643
23.02	ASC (Non-distinct Part)	1,702,593	1,549,775	1.098607
23.03	Urology Services	148,782	459,411	0.323854
23.04	Industrial Nursing	319,139	888,818	0.359060
23.05	Audiology	212,974	147,405	1.444822
23.06	Electrodiagnosis [EMG]	60,477	534,803	0.113083
23.07	Cardiovascular Labs	7,128,799	23,923,533	0.297983
23.08	Mercy Eye Center	565,273	835,384	0.676662
23.09	Wound Management	283,806	395,925	0.716818
	Outpatient Ancillary Centers			
24.	Clinic	5,621,827	7,671,165	0.732852
25.	Emergency	8,118,711	20,771,357	0.390861
26.	Observation Beds (Non-distinct Part)	276,197	589,301	0.468686
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	28,934,214	46,150	626.96
28.	Psychiatric Unit	3,196,619	6,343	503.96
29.	Rehabilitation Unit	1,425,719	4,386	325.06
30.				
31.	Intensive Care Unit	5,754,551	4,378	1,314.42
32.	Coronary Care Unit	4,005,409	3,235	1,238.15
33.	Nursery ICU/Special Care Nursery	1,152,959	2,489	463.22
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,421,850	3,653	389.23

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0158	3042
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07-01-01 To: 06-30-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	15,912		15,912
Newborn Days	2,781		2,781
Total Inpatient Revenue	48,382,269		48,382,269
Ancillary Revenue	28,219,689		28,219,689
Routine Revenue	20,162,580		20,162,580
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:

Zip code on this report is correct. [Filed report has incorrect zip code.]

Determined that the filed OHF Supplement No. 2 charges match the filed W/S C charges.