

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. James Hospital & Health Centers		Medicare Provider Number: 14-0172
Street: 20201 S. Crawford Avenue		Public Aid Provider Number: 31000
City: Olympia Fields	State: Illinois	Zip: 60461
Period Covered by Statement:	From: 01-01-02	To: 12-31-02

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 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)) St. James Hospital & Health C 31000 for the cost report beginning 01-01-02 and ending 12-31-02 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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	281	102,181		69,790	68.30%		19,290	4.05	
2.	Psychiatry	28	10,220		2,812	27.51%		525	5.36	
3.	Rehabilitation Unit	18	7,554		5,178	68.55%		572	9.05	
4.										
5.	Intensive Care Unit	36	13,140		8,294	63.12%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	41	14,965		4,188	27.99%				
16.	Total	404	148,060		90,262	60.96%		20,387	4.22	
17.	Observation Bed Days				2,284					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				9,331			2,688	3.78	
2.	Psychiatry									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				829					
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,256					
16.	Total				11,416	12.65%		2,688	3.78	

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:	14-0172	Public Aid Provider Number:	31000
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-02 To: 12-31-02

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	0.534100	789,598			421,724		
2.	Recovery Room	0.266345	77,670			20,687		
3.	Operating Room- CH	0.295292	339,199			100,163		
4.	Anesthesiology	0.065525	184,560			12,093		
5.	Radiology- Diagnostic	0.248349	951,258			236,244		
6.	Radiology- Therapeutic	0.271552	7,345			1,995		
7.	Radioisotope	0.219705	124,736			27,405		
8.	Laboratory	0.253739	2,069,160			525,027		
9.	Anesthesia- CH	0.223717	99,718			22,309		
10.	Radiology- Diagnostic- CH	0.326015	364,597			118,864		
11.	TCT Scan- CH	0.055165	328,979			18,148		
12.	Respiratory Therapy	0.209551	1,085,718			227,513		
13.	Physical Therapy	0.444213	69,647			30,938		
14.	Occupational Therapy	0.218204	28,824			6,290		
15.	Speech Pathology	0.470755	15,319			7,211		
16.	EKG	0.193536	728,340			140,960		
17.	EEG	0.245493	21,851			5,364		
18.	Med. / Surg. Supplies	0.502959	1,971,660			991,664		
19.	Drugs Charged to Patients	0.233247	1,893,171			441,576		
20.	MRI- CH	0.246711	109,260			26,956		
21.	Nuclear Medicine- CH	0.200730	191,395			38,419		
22.	Laboratory- CH	0.215693	1,528,713			329,733		
23.	Respiratory Therapy- CH	0.206712	649,000			134,156		
23.01	Physical Therapy- CH	0.424001	12,988			5,507		
23.02	Electrocardiology- CH	0.150047	394,420			59,182		
23.03	Cath Lab	0.155937	211,735			33,017		
23.04	Medical Supplies- CH	0.310661	963,733			299,394		
23.05	Drugs Sold to Patients- CH	0.261236	1,470,607			384,175		
23.06	ASC (Nondistinct Part)	0.644035	8,424			5,425		
23.07	Renal Center	0.281789	212,104			59,769		
23.08								
23.09	Contracted Services	0.795940	82,352			65,547		
Outpatient Service Cost Centers								
24.	Clinic	2.430401	8,213			19,961		
25.	Emergency	0.476562	140,342			66,882		
26.	Emergency Room- CH	0.534478	510,729			272,973		
27.	Total		17,645,365			5,157,271		

* 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatry	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 630.51	\$ 711.25	\$ 583.89	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	9,331			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 5,883,289	\$	\$	\$
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)	\$ 5,883,289	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,207.20	829	\$ 1,000,769
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 586.66	1,256	\$ 736,845
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 5,157,271
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 12,778,174

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

Medicare Provider Number: 14-0172		Public Aid Provider Number: 31000	
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-02 To: 12-31-02	

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

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Emergency Room- CH										
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:	14-0172	Public Aid Provider Number:	31000
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-02 To: 12-31-02

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									
2.	Recovery Room									
3.	Operating Room- CH									
4.	Anesthesiology	2,150,455	7,499,900	0.286731	184,560			52,919		
5.	Radiology- Diagnostic	45,826	20,805,809	0.002203	951,258			2,096		
6.	Radiology- Therapeutic									
7.	Radioisotope	2,750	4,649,239	0.000591	124,736			74		
8.	Laboratory									
9.	Anesthesia- CH									
10.	Radiology- Diagnostic- CH	116,252	13,976,594	0.008318	364,597			3,033		
11.	TCT Scan- CH									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	MRI- CH	88,369	7,511,881	0.011764	109,260			1,285		
21.	Nuclear Medicine- CH									
22.	Laboratory- CH	153,706	31,144,754	0.004935	1,528,713			7,544		
23.	Respiratory Therapy- CH									
23.01	Physical Therapy- CH	21,312	3,642,835	0.005850	12,988			76		
23.02	Electrocardiology- CH									
23.03	Cath Lab									
23.04	Medical Supplies- CH									
23.05	Drugs Sold to Patients- CH									
23.06	ASC (Nondistinct Part)									
23.07	Renal Center									
23.08										
23.09	Contracted Services									
Outpatient Ancillary Cost Centers										
24.	Clinic	212,108	1,766,875	0.120047	8,213			986		
25.	Emergency									
26.	Emergency Room- CH									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatry									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							68,013		

* 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)	12,778,174		
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)	68,013		
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)	12,846,187		
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)	17,645,365
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	8,736,779
	B. Psychiatry	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	1,781,562
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	1,133,505
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	29,297,211
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	16,451,024
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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)	12,846,187		
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)	12,846,187		
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)	12,846,187		

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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)	16,451,024
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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 Psychiatry	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 Psychiatry	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

	Adults and Pediatrics	Sub I Psychiatry	Sub II Rehabilitation Ur	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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)
Inpatient Ancillary Centers				
1.	Operating Room	9,916,473	18,566,707	0.534100
2.	Recovery Room	949,145	3,563,594	0.266345
3.	Operating Room- CH	6,328,883	21,432,636	0.295292
4.	Anesthesiology	491,434	7,499,900	0.065525
5.	Radiology- Diagnostic	5,167,107	20,805,809	0.248349
6.	Radiology- Therapeutic	1,101,616	4,056,738	0.271552
7.	Radioisotope	1,021,461	4,649,239	0.219705
8.	Laboratory	6,973,101	27,481,349	0.253739
9.	Anesthesia- CH	960,889	4,295,107	0.223717
10.	Radiology- Diagnostic- CH	4,556,576	13,976,594	0.326015
11.	TCT Scan- CH	672,030	12,182,244	0.055165
12.	Respiratory Therapy	1,794,810	8,565,011	0.209551
13.	Physical Therapy	1,834,199	4,129,094	0.444213
14.	Occupational Therapy	341,597	1,565,494	0.218204
15.	Speech Pathology	124,847	265,206	0.470755
16.	EKG	3,526,994	18,223,999	0.193536
17.	EEG	173,135	705,255	0.245493
18.	Med. / Surg. Supplies	12,992,601	25,832,340	0.502959
19.	Drugs Charged to Patients	4,298,837	18,430,371	0.233247
20.	MRI- CH	1,853,265	7,511,881	0.246711
21.	Nuclear Medicine- CH	1,141,270	5,685,602	0.200730
22.	Laboratory- CH	6,717,719	31,144,754	0.215693
23.	Respiratory Therapy- CH	1,898,126	9,182,477	0.206712
23.01	Physical Therapy- CH	1,544,565	3,642,835	0.424001
23.02	Electrocardiology- CH	1,483,051	9,883,894	0.150047
23.03	Cath Lab	1,336,217	8,568,962	0.155937
23.04	Medical Supplies- CH	6,575,112	21,164,886	0.310661
23.05	Drugs Sold to Patients- CH	6,603,951	25,279,593	0.261236
23.06	ASC (Nondistinct Part)	1,891,059	2,936,268	0.644035
23.07	Renal Center	356,691	1,265,809	0.281789
23.08				
23.09	Contracted Services	1,121,939	1,409,577	0.795940
Outpatient Ancillary Centers				
24.	Clinic	4,294,214	1,766,875	2.430401
25.	Emergency	5,682,944	11,924,884	0.476562
26.	Emergency Room- CH	5,688,267	10,642,664	0.534478
Routine Service Cost Centers				
			Total Days	Per Diem
27.	Adults and Pediatrics	45,443,503	72,074	630.51
28.	Psychiatry	2,000,022	2,812	711.25
29.	Rehabilitation Unit	3,023,377	5,178	583.89
30.				
31.	Intensive Care Unit	10,012,505	8,294	1,207.20
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,456,931	4,188	586.66

