

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. Mary's Medical Center		Medicare Provider Number: 15-0100
Street: 3700 Washington Avenue		Public Aid Provider Number: 5038
City: Evansville	State: Indiana	Zip: 47750
Period Covered by Statement:	From: 07-01-01	To: 06-30-02

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. Mary's Medical Center 5038 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)
 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: 15-0100	Public Aid Provider Number: 5038
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 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	372	139,498		64,442	46.20%		19,658	4.43	
2.	Stress Center [Psych Unit]	61	22,265		7,863	35.32%		1,143	6.88	
3.	Rehabilitation Unit	50	18,250		9,999	54.79%		818	12.22	
4.										
5.	Intensive Care Unit	41	14,878		11,037	74.18%				
6.	Coronary Care Unit	28	10,220		1,869	18.29%				
7.	Neonatal ICU	28	10,220		9,687	94.78%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	42	15,330		4,059	26.48%				
16.	Total	622	230,661		108,956	47.24%		21,619	4.85	
17.	Observation Bed Days				3,992					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				546			156	5.67	
2.	Stress Center [Psych Unit]									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				108					
6.	Coronary Care Unit				14					
7.	Neonatal ICU				216					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				46					
16.	Total				930	0.85%		156	5.67	

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:	15-0100	Public Aid Provider Number:	5038
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	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	0.399534	313,998			125,453		
2.	Recovery Room	0.435258	14,561			6,338		
3.	Delivery and Labor Room	0.771932						
4.	Anesthesiology	0.139415	15,365			2,142		
5.	Rad-Diag/CTScan/Ultrasnd/NucMe	0.262968	232,351			61,101		
6.	Radiology -Therapeutic	0.399039	5,769			2,302		
7.	Nuclear Medicine							
8.	Laboratory	0.303490	196,878			59,751		
9.	Blood							
10.	Blood - Administration	0.642130	21,448			13,772		
11.	Intravenous Therapy	0.795323	63,628			50,605		
12.	Respiratory Therapy	0.513111	169,986			87,222		
13.	Physical Therapy	0.477759	13,900			6,641		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.220739	30,072			6,638		
17.	EEG	0.441178	3,230			1,425		
18.	Med. / Surg. Supplies	0.347965	47,591			16,560		
19.	Drugs Charged to Patients	0.462013	309,741			143,104		
20.	Renal Dialysis	0.449612	2,125			955		
21.	Ambulance	0.572314	6,272			3,590		
22.	Cardiac Catheterization Laboratory	0.162933	109,518			17,844		
23.	Cardiopulmonary	1.177548						
23.01	Electroconvulsive Therapy [ECT]	1.775005						
23.02	Psychiatric/Psychological Services	0.925415						
23.03	Outreach Clinic	25.526907						
23.04	SeniorHealth/ FamilyPract/FamilyS	2.199976						
23.05	Diagnostic Treatment Center	0.853698	16,601			14,172		
23.06	Durable Medical Equip-Rented	0.811607						
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.493833	14,327			7,075		
26.	Observation Beds (Non-distinct Par	0.974190						
27.	Total		1,587,361			626,690		

* 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: 15-0100	Public Aid Provider Number: 5038
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 Stress Center [Psych I Rehabilitation Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 403.11	\$ 607.44	\$ 391.43	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	546			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 220,098	\$	\$	\$
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)	\$ 220,098	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 718.23	108	\$ 77,569
9.	Coronary Care Unit	\$ 881.17	14	\$ 12,336
10.	Neonatal ICU	\$ 562.33	216	\$ 121,463
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 195.87	46	\$ 9,010
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 626,690
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,067,166

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

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
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.	Stress Center [Psych Unit]						
4.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
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: 15-0100	Public Aid Provider Number: 5038
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	1,428,467	31,905,935	0.044771	313,998			14,058		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	158,988	3,472,490	0.045785	15,365			703		
5.	Rad-Diag/CTScan/Ultrasnd/NucMed	354,791	41,594,245	0.008530	232,351			1,982		
6.	Radiology -Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	28,025	7,275,068	0.003852	169,986			655		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG	35,618	1,522,993	0.023387	3,230			76		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Cardiac Catheterization Laboratory	39,996	22,291,809	0.001794	109,518			196		
23.	Cardiopulmonary	3,545	429,939	0.008245						
23.01	Electroconvulsive Therapy [ECT]									
23.02	Psychiatric/Psychological Services	53,717	728,673	0.073719						
23.03	Outreach Clinic	16,306	32,594	0.500276						
23.04	SeniorHealth/ FamilyPract/FamilySe	57,220	2,091,287	0.027361						
23.05	Diagnostic Treatment Center									
23.06	Durable Medical Equip-Rented									
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency	69,976	13,964,190	0.005011	14,327			72		
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	62,173	68,434	0.91	546			497		
28.	Stress Center [Psych Unit]									
29.	Rehabilitation Unit	74,037	9,999	7.40						
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	39,996	1,869	21.40	14			300		
33.	Neonatal ICU									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							18,539		

* 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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)	1,067,166		
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)	18,539		
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)	1,085,705		
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)	1,587,361
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	417,408
	B. Stress Center [Psych Unit]	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	92,932
	F. Coronary Care Unit	16,461
	G. Neonatal ICU	195,840
	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)	2,310,002
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,224,297
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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-01 To: 06-30-02

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)	1,085,705		
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)	1,085,705		
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)	1,085,705		

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: 15-0100	Public Aid Provider Number: 5038
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)	1,224,297
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: 15-0100	Public Aid Provider Number: 5038
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 Stress Center [P	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 Stress Center [P	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 Stress Center [P	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: 15-0100	Public Aid Provider Number: 5038
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	12,747,501	31,905,935	0.399534
2.	Recovery Room	2,981,155	6,849,161	0.435258
3.	Delivery and Labor Room	8,057,090	10,437,558	0.771932
4.	Anesthesiology	484,118	3,472,490	0.139415
5.	Rad-Diag/CTScan/Ultrasnd/NucMedDiag	10,937,956	41,594,245	0.262968
6.	Radiology -Therapeutic	2,365,970	5,929,174	0.399039
7.	Nuclear Medicine			
8.	Laboratory	9,820,810	32,359,543	0.303490
9.	Blood			
10.	Blood - Administration	3,233,740	5,035,959	0.642130
11.	Intravenous Therapy	1,994,948	2,508,348	0.795323
12.	Respiratory Therapy	3,732,918	7,275,068	0.513111
13.	Physical Therapy	4,936,135	10,331,862	0.477759
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	1,456,297	6,597,361	0.220739
17.	EEG	671,911	1,522,993	0.441178
18.	Med. / Surg. Supplies	24,023,961	69,041,257	0.347965
19.	Drugs Charged to Patients	17,286,827	37,416,283	0.462013
20.	Renal Dialysis	503,548	1,119,962	0.449612
21.	Ambulance	1,953,074	3,412,592	0.572314
22.	Cardiac Catheterization Laboratory	3,632,075	22,291,809	0.162933
23.	Cardiopulmonary	506,274	429,939	1.177548
23.01	Electroconvulsive Therapy [ECT]	212,635	119,794	1.775005
23.02	Psychiatric/Psychological Services	674,325	728,673	0.925415
23.03	Outreach Clinic	832,024	32,594	25.526907
23.04	SeniorHealth/ FamilyPract/FamilyServ	4,600,781	2,091,287	2.199976
23.05	Diagnostic Treatment Center	2,941,302	3,445,364	0.853698
23.06	Durable Medical Equip-Rented	922,568	1,136,718	0.811607
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	6,895,975	13,964,190	0.493833
26.	Observation Beds (Non-distinct Part)	1,585,423	1,627,427	0.974190
Routine Service Cost Centers				
			Total Days	Per Diem
27.	Adults and Pediatrics	27,586,635	68,434	403.11
28.	Stress Center [Psych Unit]	4,776,301	7,863	607.44
29.	Rehabilitation Unit	3,913,880	9,999	391.43
30.				
31.	Intensive Care Unit	7,927,080	11,037	718.23
32.	Coronary Care Unit	1,646,898	1,869	881.17
33.	Neonatal ICU	5,447,253	9,687	562.33
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	795,024	4,059	195.87

