

# 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: Saint Francis Medical Center		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Avenue		Public Aid Provider Number: 16007
City: Peoria	State: Illinois	Zip: 61637
Period Covered by Statement:	From: 10-01-01	To: 09-30-02

## 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 type="checkbox"/> Medicaid Hospital	<input checked="" type="checkbox"/> Medicaid Sub II Mental Health Unit	<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)) Saint Francis Medical Center 16007 for the cost report beginning 10-01-01 and ending 09-30-02 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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

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	337	123,005		103,141	83.85%		22,990	5.05	
2.	Rehabilitation Unit	22	8,030		6,028	75.07%		509	11.84	
3.	Mental Health Unit	13	4,745		3,158	66.55%		522	6.05	
4.										
5.	Intensive Care Unit	43	15,695		12,945	82.48%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total	415	151,475		125,272	82.70%		24,021	5.22	
17.	Observation Bed Days				5,672					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit									
3.	Mental Health Unit				377			81	4.65	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				377	0.30%		81	4.65	

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:	14-0067	Public Aid Provider Number:	16007
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 10-01-01 To: 09-30-02

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	0.395691						
2.	Recovery Room	0.279962						
3.	Delivery and Labor Room	0.868498						
4.	Anesthesiology	0.103503						
5.	Radiology - Diagnostic	0.278944	10,366			2,892		
6.	Infant Apnea	1.087808						
7.	Psychology	1.223399	59,955			73,349		
8.	Laboratory	0.154017	41,229			6,350		
9.	Pediatric Special Clinic							
10.	Blood - Administration	0.560541						
11.	Eating Disorders Clinic	2.031505						
12.	Respiratory Therapy	0.169798						
13.	Urological	0.442738						
14.	Lithotripsy	0.381981						
15.	Speech Pathology & Audiology	0.468037						
16.	EKG	0.139752	910			127		
17.	EEG	0.704786						
18.	Med. / Surg. Supplies	0.206299	8,103			1,672		
19.	Drugs Charged to Patients	0.255356	22,589			5,768		
20.	Renal Dialysis	0.491648						
21.	Ambulance Services	0.622404						
22.	PBP Clinical Lab Services Pgm	0.007561						
23.	Digestive Diseases	0.155940						
23.01	Enterostomal	0.911163						
23.02	Non-invasive Laboratory							
23.03	Rehabilitation Services	0.571687	71,188			40,697		
23.04	Cardiac Catheter Lab	0.309024						
23.05	Krasse Health Center	5.065136						
23.06	Special Clinics	0.852963	137			117		
23.07	Sisters Clinic	5.338702						
23.08	Diabetic Service	3.669955						
23.09	Cardiopulmonary Rehab	0.823736						
<b>Outpatient Service Cost Centers</b>								
24.	Sleep Disorders	0.333401						
25.	Emergency	0.615432	742			457		
26.	Observation Beds (Non-distinct Par							
27.	<b>Total</b>		215,219			131,429		

\* 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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Mental Health Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 648.04	\$ 495.43	\$ 648.04	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			377	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 244,311	\$
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)	\$	\$	\$ 244,311	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,323.88		\$
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 131,429
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 375,740</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> 14-0067	<b>Public Aid Provider Number:</b> 16007
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-01 To: 09-30-02

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.	Rehabilitation Unit						
4.	Mental Health 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.	Sleep Disorders										
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:	14-0067	Public Aid Provider Number:	16007
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 10-01-01 To: 09-30-02

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	114,400	127,901,210	0.000894						
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	1,425,194	152,581,421	0.009341	10,366			97		
6.	Infant Apnea									
7.	Psychology									
8.	Laboratory									
9.	Pediatric Special Clinic									
10.	Blood - Administration									
11.	Eating Disorders Clinic									
12.	Respiratory Therapy	10,154	42,699,928	0.000238						
13.	Urological									
14.	Lithotripsy									
15.	Speech Pathology & Audiology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance Services									
22.	PBP Clinical Lab Services Pgm									
23.	Digestive Diseases									
23.01	Enterostomal									
23.02	Non-invasive Laboratory									
23.03	Rehabilitation Services	498,064	13,730,243	0.036275	71,188			2,582		
23.04	Cardiac Catheter Lab									
23.05	Krasse Health Center									
23.06	Special Clinics	103,807	431,320	0.240673	137			33		
23.07	Sisters Clinic									
23.08	Diabetic Service									
23.09	Cardiopulmonary Rehab									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Sleep Disorders									
25.	Emergency	2,306,888	33,449,560	0.068966	742			51		
26.	Observation Beds (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	533,358	108,813	4.90						
28.	Rehabilitation Unit									
29.	Mental Health Unit	15,479	3,158	4.90	377			1,847		
30.										
31.	Intensive Care Unit	113,485	12,945	8.77						
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							4,610		

\* 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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

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)	375,740		
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)	4,610		
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>	380,350		
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)	215,219
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	
	C. Mental Health Unit	156,515
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	371,734
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	(8,616)
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	(8,616)

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

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)	380,350		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)	(8,616)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	371,734		
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>	371,734		

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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

**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)
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)				8,616	8,616
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)				8,616	8,616

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

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

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

OHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-01 To: 09-30-02

**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 Rehabilitation Ur	Sub II Mental Health 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 Rehabilitation Ur	Sub II Mental Health 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 Rehabilitation Ur	Sub II Mental Health 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**

<b>Medicare Provider Number:</b> 14-0067	<b>Public Aid Provider Number:</b> 16007
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-01 To: 09-30-02

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	50,609,306	127,901,210	0.395691
2.	Recovery Room	2,105,459	7,520,527	0.279962
3.	Delivery and Labor Room	4,553,733	5,243,229	0.868498
4.	Anesthesiology	2,687,530	25,965,635	0.103503
5.	Radiology - Diagnostic	42,561,688	152,581,421	0.278944
6.	Infant Apnea	310,097	285,066	1.087808
7.	Psychology	426,077	348,273	1.223399
8.	Laboratory	24,777,172	160,872,824	0.154017
9.	Pediatric Special Clinic			
10.	Blood - Administration	3,613,183	6,445,889	0.560541
11.	Eating Disorders Clinic	304,937	150,104	2.031505
12.	Respiratory Therapy	7,250,359	42,699,928	0.169798
13.	Urological	147,713	333,635	0.442738
14.	Lithotripsy	478,805	1,253,479	0.381981
15.	Speech Pathology & Audiology	766,393	1,637,461	0.468037
16.	EKG	1,584,225	11,335,953	0.139752
17.	EEG	818,462	1,161,292	0.704786
18.	Med. / Surg. Supplies	11,175,911	54,173,420	0.206299
19.	Drugs Charged to Patients	16,556,183	64,835,812	0.255356
20.	Renal Dialysis	1,584,459	3,222,752	0.491648
21.	Ambulance Services	4,788,713	7,693,897	0.622404
22.	PBP Clinical Lab Services Pgm	142,185	18,806,029	0.007561
23.	Digestive Diseases	3,020,458	19,369,357	0.155940
23.01	Enterostomal	143,674	157,682	0.911163
23.02	Non-invasive Laboratory			
23.03	Rehabilitation Services	7,849,401	13,730,243	0.571687
23.04	Cardiac Catheter Lab	14,054,471	45,480,135	0.309024
23.05	Krasse Health Center	1,903,625	375,829	5.065136
23.06	Special Clinics	367,900	431,320	0.852963
23.07	Sisters Clinic	4,069,463	762,257	5.338702
23.08	Diabetic Service	722,071	196,752	3.669955
23.09	Cardiopulmonary Rehab	830,519	1,008,235	0.823736
<b>Outpatient Ancillary Centers</b>				
24.	Sleep Disorders	1,207,990	3,623,237	0.333401
25.	Emergency	20,585,914	33,449,560	0.615432
26.	Observation Beds (Non-distinct Part)		2,996,001	
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	70,515,314	108,813	648.04
28.	Rehabilitation Unit	2,986,429	6,028	495.43
29.	Mental Health Unit	2,046,520	3,158	648.04
30.				
31.	Intensive Care Unit	17,137,590	12,945	1,323.88
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery			

