

Hospital Statement of Cost

Illinois Department of Public Aid, Office of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Union Hospital, Inc.		Medicare Provider Number: 15-0023	
Street: 1606 North 7th Street		Public Aid Provider Number: 20003	
City: Terre Haute	State: Indiana	Zip: 47804	
Period Covered by Statement:	From: 09-01-02	To: 08-31-03	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Union Hospital, Inc. 20003 for the cost report beginning 09-01-02 and ending 08-31-03 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Public Aid Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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	197	71,947	13,887	44,511	61.87%		11,695	4.65	
2.	Medical Rehab	18	6,570		5,339	81.26%		430	12.42	
3.										
4.										
5.	Intensive Care Unit	32	11,680		8,052	68.94%				
6.	Coronary Care Unit									
7.	Intensive Nursery	9	3,285		1,863	56.71%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	32	11,680		2,535	21.70%				
16.	Total	288	105,162	13,887	62,300	59.24%		12,125	4.93	
17.	Observation Bed Days				6,437					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			42	643			269	3.35	
2.	Medical Rehab									
3.										
4.										
5.	Intensive Care Unit				79					
6.	Coronary Care Unit									
7.	Intensive Nursery				179					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				183					
16.	Total			42	1,084	1.74%		269	3.35	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number:	15-0023	Public Aid Provider Number:	20003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09-01-02 To: 08-31-03

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	0.279834	346,962			97,092		
2.	Recovery Room	0.516761	53,448			27,620		
3.	Delivery and Labor Room	0.558296	195,131			108,941		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.615565	65,858			40,540		
6.	Radiology - Therapeutic	0.373910	6,210			2,322		
7.	Radioisotope	0.434962	6,225			2,708		
8.	Laboratory	0.164962	214,492			35,383		
9.	Blood							
10.	Blood - Administration	0.815415	16,333			13,318		
11.	Intravenous Therapy	0.084459	174,327			14,723		
12.	Respiratory Therapy	0.477683	39,734			18,980		
13.	Physical Therapy	0.574526	8,806			5,059		
14.	Occupational Therapy	0.449588	6,238			2,805		
15.	Speech Pathology	0.527541	7,352			3,878		
16.	EKG	0.216359	29,563			6,396		
17.	EEG	0.181949	4,310			784		
18.	Med. / Surg. Supplies	0.407411	118,695			48,358		
19.	Drugs Charged to Patients	0.239294	516,359			123,562		
20.	Renal Acute/ Renal CAPD	0.587843	663			390		
21.	Ambulance							
22.	Cardiac Surgery (Open Heart Surge	0.353723						
23.	WVSC	0.329889						
23.01	O/P Treatment Room	0.855936	43,265			37,032		
23.02	CT Scan	0.166031	61,130			10,149		
23.03	Cardiac Catheterization Laboratory	0.394496	55,634			21,947		
23.04	Psychiatric/ Psychological Services	0.502242						
23.05	O/P Physical Therapy	0.652987						
23.06	MHC/Family/Phys Prac/PainClin	1.468089						
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.370854	32,402			12,016		
26.	Observ. Bds (Non-distinct)	0.578812						
27.	Total		2,003,137			634,003		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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

Line No.	Description	Adults and Pediatrics	Sub I Medical Rehab	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 464.60	\$ 594.98	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	643			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 298,738	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 252.72	\$	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)	42			
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$ 10,614	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 309,352	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,052.72	79	\$ 83,165
9.	Coronary Care Unit	\$		\$
10.	Intensive Nursery	\$ 706.80	179	\$ 126,517
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 375.06	183	\$ 68,636
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 634,003
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,221,673

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

Medicare Provider Number: 15-0023		Public Aid Provider Number: 20003	
Program: Medicaid-Hospital		Period Covered by Statement: From: 09-01-02 To: 08-31-03	

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Medical Rehab						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Intensive Nursery						
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observ. Bds (Non-distinct)										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

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

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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	4,192,470	58,197,433	0.072039	346,962			24,995		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	5,299,019	15,545,482	0.340872	65,858			22,449		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	47,008	5,823,340	0.008072	29,563			239		
17.	EEG	175,870	1,545,878	0.113767	4,310			490		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Acute/ Renal CAPD									
21.	Ambulance									
22.	Cardiac Surgery (Open Heart Surger	183,895	5,736,603	0.032056						
23.	WVSC									
23.01	O/P Treatment Room									
23.02	CT Scan									
23.03	Cardiac Catheterization Laboratory	154,260	24,159,970	0.006385	55,634			355		
23.04	Psychiatric/ Psychological Services									
23.05	O/P Physical Therapy									
23.06	MHC/Family/Phys Prac/PainClin	1,666,720	6,625,752	0.251552						
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observ. Bds (Non-distinct)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Medical Rehab									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Intensive Nursery									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							48,528		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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)	1,221,673		
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)	48,528		
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)	1,270,201		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	2,003,137
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	409,885
	B. Medical Rehab	
	C.	
	D.	
	E. Intensive Care Unit	100,725
	F. Coronary Care Unit	
	G. Intensive Nursery	226,600
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	105,450
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	2,845,797
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,575,596
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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)	1,270,201		
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)	1,270,201		
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)	1,270,201		

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: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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)	1,575,596
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

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

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

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Medical Rehab	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I Medical Rehab	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Medical Rehab	Sub II	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)	38,869,085			
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	24,623,670			
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	14,245,415			
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	37,061			
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	13,887			
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	1,025.81			
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	664.41			
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	361.40			
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))	252.72			
7. Private room cost differential adjustment (Line 2B X Line 6)	3,509,523			
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)	23,670,595			
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)	464.60			

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

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	16,285,648	58,197,433	0.279834
2.	Recovery Room	2,847,565	5,510,412	0.516761
3.	Delivery and Labor Room	3,029,961	5,427,158	0.558296
4.	Anesthesiology			
5.	Radiology - Diagnostic	9,569,256	15,545,482	0.615565
6.	Radiology - Therapeutic	3,067,749	8,204,505	0.373910
7.	Radioisotope	1,779,074	4,090,184	0.434962
8.	Laboratory	4,187,360	25,383,816	0.164962
9.	Blood			
10.	Blood - Administration	1,518,454	1,862,185	0.815415
11.	Intravenous Therapy	1,230,321	14,567,047	0.084459
12.	Respiratory Therapy	2,485,833	5,203,943	0.477683
13.	Physical Therapy	1,516,501	2,639,568	0.574526
14.	Occupational Therapy	1,203,238	2,676,314	0.449588
15.	Speech Pathology	560,083	1,061,686	0.527541
16.	EKG	1,259,930	5,823,340	0.216359
17.	EEG	281,271	1,545,878	0.181949
18.	Med. / Surg. Supplies	1,692,453	4,154,169	0.407411
19.	Drugs Charged to Patients	12,011,813	50,196,926	0.239294
20.	Renal Acute/ Renal CAPD	566,180	963,148	0.587843
21.	Ambulance			
22.	Cardiac Surgery (Open Heart Surgery)	2,029,166	5,736,603	0.353723
23.	WVSC	4,017,512	12,178,363	0.329889
23.01	O/P Treatment Room	2,448,427	2,860,525	0.855936
23.02	CT Scan	2,087,394	12,572,334	0.166031
23.03	Cardiac Catheterization Laboratory	9,531,017	24,159,970	0.394496
23.04	Psychiatric/ Psychological Services	419,689	835,631	0.502242
23.05	O/P Physical Therapy	1,741,758	2,667,370	0.652987
23.06	MHC/Family/Phys Prac/PainClin	9,727,192	6,625,752	1.468089
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	4,708,577	12,696,583	0.370854
26.	Observ. Bds (Non-distinct)	3,313,060	5,723,894	0.578812
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics			See Supplement 1
28.	Medical Rehab	3,176,580	5,339	594.98
29.				
30.				
31.	Intensive Care Unit	8,476,521	8,052	1,052.72
32.	Coronary Care Unit			
33.	Intensive Nursery	1,316,770	1,863	706.80
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	950,770	2,535	375.06

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

PRELIMINARY

Medicare Provider Number: 15-0023	Public Aid Provider Number: 20003
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-02 To: 08-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	901		901
Newborn Days	183		183
Total Inpatient Revenue	2,845,848	(51)	2,845,797
Ancillary Revenue	2,003,188	(51)	2,003,137
Routine Revenue	842,660		842,660
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:

Filed IL Medicaid days, unadjusted IL Medicaid discharges and filed IL Medicaid charges were taken from the filed Log 309/ Inpatient Log summary.

Prior to FYE 08-31-01, filed reports have no IL Medicaid utilization of Medical Rehab. The utilization of 21 days is included with A&P.

[That is consistent with the FYE 08-31-01 and 08-31-02 PRELIMs.]

Removed \$51 Cardiac Rehab charges. Cardiac Rehab is noncovered for IL Medicaid.

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

Medicaid days and charges for Intensive Nursery and Nursery were taken from the filed OHF report.

Total Private Room Days = 13,887 was taken from the filed OHF-2.

