

# 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: Ingalls Hospital		Medicare Provider Number: 14-0191	
Street: One Ingalls Drive		Public Aid Provider Number: 8006	
City: Harvey	State: Illinois	Zip: 60426	
Period Covered by Statement:	From: 10-01-02	To: 09-30-03	

**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 XXXX XXXX	<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 XXXX XXXX	<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 XXXX XXXX	<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)) Ingalls Hospital 8006 for the cost report beginning 10-01-02 and ending 09-30-03 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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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	207	75,555		68,656	90.87%		16,295	4.67	
2.	Psychiatry	32	11,680		7,967	68.21%		1,211	6.58	
3.	Rehabilitation Unit	42	15,330		12,939	84.40%		1,004	12.89	
4.										
5.	Intensive Care Unit	10	3,650		3,043	83.37%				
6.	Coronary Care Unit	15	5,475		4,348	79.42%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	26	9,490		2,253	23.74%				
16.	Total	332	121,180		99,206	81.87%		18,510	5.24	
17.	Observation Bed Days				577					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				10,577			2,441	4.67	
2.	Psychiatry									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				352					
6.	Coronary Care Unit				470					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				909					
16.	Total				12,308	12.41%		2,441	4.67	

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:	14-0191	Public Aid Provider Number:	8006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10-01-02 To: 09-30-03

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	0.384913	1,729,841			665,838		
2.	Recovery Room	0.453229	227,367			103,049		
3.	Delivery and Labor Room	0.848466	1,706,133			1,447,596		
4.	Anesthesiology	0.220867	272,539			60,195		
5.	Radiology - Diagnostic	0.360147	565,826			203,781		
6.	FCC Clinics	0.283019	55,078			15,588		
7.	Radioisotope	0.207455	444,856			92,288		
8.	Laboratory	0.220550	3,770,815			831,653		
9.	Blood							
10.	Blood - Administration	0.329388	553,861			182,435		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.278993	936,546			261,290		
13.	Physical Therapy	0.444008	200,588			89,063		
14.	Occupational Therapy	0.277199	84,289			23,365		
15.	Speech Pathology	0.444087	58,035			25,773		
16.	EKG	0.100027	1,215,192			121,552		
17.	EMG	0.434258	82,149			35,674		
18.	Med. / Surg. Supplies	0.163394	1,044,898			170,730		
19.	Drugs Charged to Patients	0.256388	5,799,138			1,486,829		
20.	Renal Dialysis	0.519836	206,065			107,120		
21.	Lithotripsy	0.405014						
22.	MRI	0.189055	405,848			76,728		
23.	CT Scan	0.084955	1,011,600			85,940		
23.01	Ultrasound	0.253554	423,137			107,288		
23.02	Special Procedures	0.320961	347,067			111,395		
23.03	ASC (Non-distinct Part)	0.557478						
23.04	Psych Services	0.825169						
23.05	Retinal Vascular	0.762889	2,375			1,812		
23.06	Pulmonary Function	0.130149	37,400			4,868		
23.07	Hemodynamics	0.396334	542,579			215,043		
23.08	Infusion Therapy	0.431586	295			127		
23.09	Wound Clinic	0.435243	22,753			9,903		
<b>Outpatient Service Cost Centers</b>								
24.	Diabetes Ed Clinic							
25.	Emergency	0.248622	2,701,409			671,630		
26.	Observation Beds (Non-distinct Par	0.470133						
27.	<b>Total</b>		24,447,679			7,208,553		

\* 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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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)	\$ 537.68	\$ 724.07	\$ 544.80	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	10,577			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 5,687,041	\$	\$	\$
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)	\$ 5,687,041	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,197.40	352	\$ 421,485
9.	Coronary Care Unit	\$ 1,284.92	470	\$ 603,912
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 632.62	909	\$ 575,052
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 7,208,553
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 14,496,043</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> 14-0191	<b>Public Aid Provider Number:</b> 8006
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

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.	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.	Diabetes Ed 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: <b>14-0191</b>	Public Aid Provider Number: <b>8006</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>10-01-02</b> To: <b>09-30-03</b>

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	FCC Clinics									
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									
17.	EMG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Lithotripsy									
22.	MRI									
23.	CT Scan									
23.01	Ultrasound									
23.02	Special Procedures									
23.03	ASC (Non-distinct Part)									
23.04	Psych Services									
23.05	Retinal Vascular									
23.06	Pulmonary Function									
23.07	Hemodynamics									
23.08	Infusion Therapy									
23.09	Wound Clinic									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Diabetes Ed Clinic									
25.	Emergency									
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									
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.	<b>Total</b>									

\* 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**

<b>Medicare Provider Number:</b> 14-0191		<b>Public Aid Provider Number:</b> 8006		
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	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)	14,496,043		
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)			
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>	14,496,043		
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)	24,447,679
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	7,771,295
	B. Psychiatry	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	452,641
	F. Coronary Care Unit	602,977
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	476,513
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	33,751,105
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	19,255,062
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**

<b>Medicare Provider Number:</b> 14-0191	<b>Public Aid Provider Number:</b> 8006
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

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)	14,496,043		
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)	14,496,043		
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>	14,496,043		

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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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)	19,255,062
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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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 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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	15,654,099	40,669,236	0.384913
2.	Recovery Room	1,514,564	3,341,716	0.453229
3.	Delivery and Labor Room	4,150,787	4,892,109	0.848466
4.	Anesthesiology	860,921	3,897,921	0.220867
5.	Radiology - Diagnostic	9,124,149	25,334,484	0.360147
6.	FCC Clinics	11,258,866	39,781,374	0.283019
7.	Radioisotope	1,889,116	9,106,168	0.207455
8.	Laboratory	11,668,674	52,907,102	0.220550
9.	Blood			
10.	Blood - Administration	1,776,537	5,393,454	0.329388
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,785,730	9,984,954	0.278993
13.	Physical Therapy	7,620,529	17,163,034	0.444008
14.	Occupational Therapy	1,517,828	5,475,592	0.277199
15.	Speech Pathology	551,095	1,240,961	0.444087
16.	EKG	1,735,046	17,345,705	0.100027
17.	EMG	1,227,298	2,826,193	0.434258
18.	Med. / Surg. Supplies	3,046,525	18,645,258	0.163394
19.	Drugs Charged to Patients	10,915,169	42,572,828	0.256388
20.	Renal Dialysis	1,098,399	2,112,974	0.519836
21.	Lithotripsy	406,729	1,004,235	0.405014
22.	MRI	1,699,084	8,987,224	0.189055
23.	CT Scan	1,455,404	17,131,568	0.084955
23.01	Ultrasound	1,639,300	6,465,300	0.253554
23.02	Special Procedures	1,924,265	5,995,328	0.320961
23.03	ASC (Non-distinct Part)	2,092,531	3,753,565	0.557478
23.04	Psych Services	641,437	777,340	0.825169
23.05	Retinal Vascular	1,151,017	1,508,760	0.762889
23.06	Pulmonary Function	144,740	1,112,113	0.130149
23.07	Hemodynamics	6,026,370	15,205,300	0.396334
23.08	Infusion Therapy	475,581	1,101,937	0.431586
23.09	Wound Clinic	1,062,098	2,440,243	0.435243
<b>Outpatient Ancillary Centers</b>				
24.	Diabetes Ed Clinic			
25.	Emergency	7,064,668	28,415,318	0.248622
26.	Observation Beds (Non-distinct Part)	317,863	676,113	0.470133
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	37,225,340	69,233	537.68
28.	Psychiatry	5,768,666	7,967	724.07
29.	Rehabilitation Unit	7,049,203	12,939	544.80
30.				
31.	Intensive Care Unit	3,643,684	3,043	1,197.40
32.	Coronary Care Unit	5,586,818	4,348	1,284.92
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,425,302	2,253	632.62

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

PRELIMINARY

Medicare Provider Number: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,399		11,399
Newborn Days	909		909
Total Inpatient Revenue	33,758,028	(6,923)	33,751,105
Ancillary Revenue	24,454,602	(6,923)	24,447,679
Routine Revenue	9,303,426		9,303,426
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

- Filed OHF Supplement No. 2 charges match the filed W/S C charges.
- Reclassified Radiology-Therapeutic charges as MRI. Determined per cost-to-charge ratio.
- Reclassified Blood charges as Blood Administration. Blood is noncovered.
- Reclassified Intravenous Therapy charges as Infusion Therapy. Determined per cost-to-charge ratio.
- Reclassified EEG charges as EMG. Determined per cost-to-charge ratio.
- Reclassified Ambulance charges as Special Procedures. Determined per cost-to-charge ratio.
- Removed \$6,923 Cardiac Rehab charges Cardiac Rehab is noncovered for Illinois Medicaid.
- Reclassified Clinic charges as Wound Clinic. Determined per cost-to-charge ratio.