

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: 09/01/03	To: 08/31/04	

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 09/01/03 and ending 08/31/04 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: 09/01/03 To: 08/31/04

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	200	73,095	17,073	46,398	63.48%		12,571	4.53	
2.	Medical Rehab	28	10,248		8,171	79.73%		697	11.72	
3.										
4.										
5.	Intensive Care Unit	32	11,712		8,606	73.48%				
6.	Coronary Care Unit									
7.	Intensive Nursery	9	3,294		1,976	59.99%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	32	11,712		2,602	22.22%				
16.	Total	301	110,061	17,073	67,753	61.56%		13,268	4.91	
17.	Observation Bed Days				7,256					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			48	757			423	2.35	
2.	Medical Rehab									
3.										
4.										
5.	Intensive Care Unit				78					
6.	Coronary Care Unit									
7.	Intensive Nursery				161					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				244					
16.	Total			48	1,240	1.83%		423	2.35	

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: 09/01/03 To: 08/31/04

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	0.271411	530,197			143,901		
2.	Recovery Room	0.512653	67,043			34,370		
3.	Delivery and Labor Room	0.547625	340,580			186,510		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.608561	75,348			45,854		
6.	Radiology - Therapeutic	0.366934	5,288			1,940		
7.	Radioisotope	0.451665	6,136			2,771		
8.	Laboratory	0.149546	283,578			42,408		
9.	Blood							
10.	Blood - Administration	0.846005	23,574			19,944		
11.	Intravenous Therapy	0.067222	220,605			14,830		
12.	Respiratory Therapy	0.474714	35,643			16,920		
13.	Physical Therapy	0.553984	11,961			6,626		
14.	Occupational Therapy	0.472694	7,664			3,623		
15.	Speech Pathology	0.546579	12,010			6,564		
16.	EKG	0.207594	39,532			8,207		
17.	EEG	0.195728	1,880			368		
18.	Med. / Surg. Supplies	0.439153	175,195			76,937		
19.	Drugs Charged to Patients	0.230783	652,329			150,546		
20.	Renal Acute/ Renal CAPD	0.615914	4,098			2,524		
21.	Ambulance							
22.	Cardiac Surgery	0.384668						
23.	WVSC	0.331592						
23.01	O/P Treatment Room	0.926690	45,353			42,028		
23.02	CT Scan	0.150177	74,525			11,192		
23.03	Cardiac Catheterization Laboratory	0.377729	94,463			35,681		
23.04	Psychiatric/ Psychological Services	0.653871						
23.05	O/P Physical Therapy	0.651464						
23.06	Physicians Practice	1.461085						
23.07	Family Practice	3.824683						
23.08								
23.09								
Outpatient Service Cost Centers								
24.	MHC	0.548394						
25.	Emergency	0.350977	28,738			10,086		
26.	Observ. Bds (Non-distinct)	0.563350						
27.	Total		2,735,740			863,830		

* 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: 09/01/03 To: 08/31/04

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)	\$ 499.30	\$ 582.14	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	757			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 377,970	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 200.87	\$	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)	48			
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$ 9,642	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 387,612	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,084.55	78	\$ 84,595
9.	Coronary Care Unit	\$		\$
10.	Intensive Nursery	\$ 697.21	161	\$ 112,251
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 408.11	244	\$ 99,579
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 863,830
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,547,867

**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: 09/01/03 To: 08/31/04

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.	MHC										
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: 09/01/03 To: 08/31/04

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	5,022,180	74,277,660	0.067614	530,197			35,849		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	6,388,150	18,074,405	0.353436	75,348			26,631		
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	87,086	7,186,568	0.012118	39,532			479		
17.	EEG	156,085	1,602,038	0.097429	1,880			183		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Acute/ Renal CAPD									
21.	Ambulance									
22.	Cardiac Surgery	177,225	6,695,602	0.026469						
23.	WVSC									
23.01	O/P Treatment Room									
23.02	CT Scan									
23.03	Cardiac Catheterization Laboratory	185,610	33,619,945	0.005521	94,463			522		
23.04	Psychiatric/ Psychological Services									
23.05	O/P Physical Therapy	3,620	3,152,199	0.001148						
23.06	Physicians Practice									
23.07	Family Practice	33,025	1,395,696	0.023662						
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	MHC	105,556	823,508	0.128178						
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							63,664		

* 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: 09/01/03 To: 08/31/04

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)	1,547,867		
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)	63,664		
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)	1,611,531		
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)	2,735,740
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	541,720
	B. Medical Rehab	
	C.	
	D.	
	E. Intensive Care Unit	108,700
	F. Coronary Care Unit	
	G. Intensive Nursery	226,900
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	160,475
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	3,773,535
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,162,004
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: 09/01/03 To: 08/31/04

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)	1,611,531		
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)	1,611,531		
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)	1,611,531		

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: 09/01/03 To: 08/31/04

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)	2,162,004
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 (1)	to (2)	to (3)		
		(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)
			(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: 09/01/03 To: 08/31/04

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)	47,806,240			
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	28,895,083			
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	18,911,157			
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	36,581			
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	17,073			
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	1,107.66			
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	789.89			
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	317.77			
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))	200.87			
7. Private room cost differential adjustment (Line 2B X Line 6)	3,429,454			
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)	26,789,460			
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)	499.30			

**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: 09/01/03 To: 08/31/04

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	20,159,792	74,277,660	0.271411
2.	Recovery Room	3,269,238	6,377,093	0.512653
3.	Delivery and Labor Room	3,473,744	6,343,288	0.547625
4.	Anesthesiology			
5.	Radiology - Diagnostic	10,999,380	18,074,405	0.608561
6.	Radiology - Therapeutic	3,334,198	9,086,631	0.366934
7.	Radioisotope	1,811,456	4,010,620	0.451665
8.	Laboratory	4,610,501	30,829,991	0.149546
9.	Blood			
10.	Blood - Administration	1,845,551	2,181,489	0.846005
11.	Intravenous Therapy	1,116,436	16,608,140	0.067222
12.	Respiratory Therapy	2,803,562	5,905,788	0.474714
13.	Physical Therapy	1,644,905	2,969,229	0.553984
14.	Occupational Therapy	1,478,013	3,126,786	0.472694
15.	Speech Pathology	737,680	1,349,630	0.546579
16.	EKG	1,491,888	7,186,568	0.207594
17.	EEG	313,564	1,602,038	0.195728
18.	Med. / Surg. Supplies	1,828,944	4,164,707	0.439153
19.	Drugs Charged to Patients	13,325,002	57,738,346	0.230783
20.	Renal Acute/ Renal CAPD	688,809	1,118,352	0.615914
21.	Ambulance			
22.	Cardiac Surgery	2,575,582	6,695,602	0.384668
23.	WVSC	4,825,824	14,553,501	0.331592
23.01	O/P Treatment Room	2,820,523	3,043,653	0.926690
23.02	CT Scan	2,350,914	15,654,338	0.150177
23.03	Cardiac Catheterization Laboratory	12,699,214	33,619,945	0.377729
23.04	Psychiatric/ Psychological Services	499,396	763,753	0.653871
23.05	O/P Physical Therapy	2,053,544	3,152,199	0.651464
23.06	Physicians Practice	7,422,995	5,080,469	1.461085
23.07	Family Practice	5,338,095	1,395,696	3.824683
23.08				
23.09				
Outpatient Ancillary Centers				
24.	MHC	451,607	823,508	0.548394
25.	Emergency	5,597,057	15,947,079	0.350977
26.	Observ. Bds (Non-distinct)	3,940,588	6,994,914	0.563350
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics			See Supplement 1
28.	Medical Rehab	4,756,676	8,171	582.14
29.				
30.				
31.	Intensive Care Unit	9,333,638	8,606	1,084.55
32.	Coronary Care Unit			
33.	Intensive Nursery	1,377,693	1,976	697.21
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,061,913	2,602	408.11

**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: 09/01/03 To: 08/31/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	996		996
Newborn Days	244		244
Total Inpatient Revenue	3,773,759	(224)	3,773,535
Ancillary Revenue	2,735,964	(224)	2,735,740
Routine Revenue	1,037,795		1,037,795
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 408/ Inpatient Log summary.

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

[That is consistent with the FYE 08-31-01 through 08-31-03 PRELIMS.]

Removed \$224 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 = 17,073 was taken from the filed OHF-2.

