

# 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: Sherman Hospital		Medicare Provider Number: 14-0030	
Street: 934 Center Street		Public Aid Provider Number: 5006	
City: Elgin	State: Illinois	Zip: 60120	
Period Covered by Statement:	From: 05-01-03	To: 04-30-04	

**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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) XXXX XXXX	<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)) Sherman Hospital 5006 for the cost report beginning 05-01-03 and ending 04-30-04 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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

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	311	113,826		51,690	45.41%		16,916	3.47	
2.										
3.										
4.										
5.	Intensive Care Unit	18	6,588		4,086	62.02%				
6.	Coronary Care Unit	10	3,660		2,867	78.33%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	47	17,202		6,439	37.43%				
16.	Total	386	141,276		65,082	46.07%		16,916	3.47	
17.	Observation Bed Days				732					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				6,257			2,399	2.80	
2.										
3.										
4.										
5.	Intensive Care Unit				329					
6.	Coronary Care Unit				131					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				3,542					
16.	Total				10,259	15.76%		2,399	2.80	

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:	14-0030	Public Aid Provider Number:	5006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 05-01-03 To: 04-30-04

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	0.445900	1,454,160			648,410		
2.	Recovery Room	0.545340	147,146			80,245		
3.	Delivery and Labor Room	0.562150	2,202,294			1,238,020		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.236224	1,665,127			393,343		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.229744	3,110,791			714,686		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	0.745771	3,572			2,664		
12.	Respiratory Therapy	0.269291	665,626			179,247		
13.	Physical Therapy	0.416394	96,514			40,188		
14.	Occupational Therapy	0.640760	33,137			21,233		
15.	Speech Pathology	0.435518	20,728			9,027		
16.	EKG	0.310861	1,125,560			349,893		
17.	EEG	0.462320	18,611			8,604		
18.	Med. / Surg. Supplies	0.161816	2,796,404			452,503		
19.	Drugs Charged to Patients	0.224960	5,736,857			1,290,563		
20.	Renal Dialysis	0.462978	88,513			40,980		
21.	Ambulance							
22.	Pulmonary Function	0.183111	625,930			114,615		
23.	Wound Care Center	0.960605	971			933		
23.01	Diabetes Center	0.100709	5,794			584		
23.02	Clinical Nutrition (Services)	0.737573	128,860			95,044		
23.03	S.C.O.R.E.	0.245156						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.561534	914,439			513,489		
26.	Treatment/Observ Beds (Non-distin	0.814700						
27.	<b>Total</b>		20,841,034			6,194,271		

\* 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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 671.65	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	6,257			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 4,202,514	\$	\$	\$
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)	\$ 4,202,514	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,316.91	329	\$ 433,263
9.	Coronary Care Unit	\$ 1,530.48	131	\$ 200,493
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 464.97	3,542	\$ 1,646,924
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 6,194,271
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 12,677,465</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> 14-0030	<b>Public Aid Provider Number:</b> 5006
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 05-01-03 To: 04-30-04

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.							
4.							
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.	Clinic										
14.	Emergency										
15.	Treatment/Observ Beds (Non-dis										
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>14-0030</b>	Public Aid Provider Number: <b>5006</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>05-01-03</b> To: <b>04-30-04</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	26,000	55,046,225	0.000472	1,454,160			686		
2.	Recovery Room									
3.	Delivery and Labor Room	168,667	8,026,735	0.021013	2,202,294			46,277		
4.	Anesthesiology									
5.	Radiology - Diagnostic	53,390	63,587,590	0.000840	1,665,127			1,399		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	24,000	44,343,502	0.000541	3,110,791			1,683		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	6,875	10,521,826	0.000653	665,626			435		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	60,000	67,275,340	0.000892	1,125,560			1,004		
17.	EEG	5,000	1,907,943	0.002621	18,611			49		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	80,000	8,292,783	0.009647	88,513			854		
21.	Ambulance									
22.	Pulmonary Function									
23.	Wound Care Center									
23.01	Diabetes Center	24,075	6,938,248	0.003470	5,794			20		
23.02	Clinical Nutrition (Services)									
23.03	S.C.O.R.E.	500	462,012	0.001082						
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	6,854,593	23,400,858	0.292921	914,439			267,858		
26.	Treatment/Observ Beds (Non-distinc									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	153,250	6,439	23.80	3,542			84,300		
37.	<b>Total</b>							404,565		

\* 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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

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)	12,677,465		
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)	404,565		
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>	13,082,030		
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)	20,841,034
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	5,150,036
	B.	
	C.	
	D.	
	E. Intensive Care Unit	731,875
	F. Coronary Care Unit	299,206
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	3,374,555
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	30,396,706
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	17,314,676
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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

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)	13,082,030		
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)	13,082,030		
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>	13,082,030		

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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

**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)	17,314,676
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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

**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	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	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	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)				
(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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	24,545,126	55,046,225	0.445900
2.	Recovery Room	4,506,294	8,263,268	0.545340
3.	Delivery and Labor Room	4,512,232	8,026,735	0.562150
4.	Anesthesiology			
5.	Radiology - Diagnostic	15,020,944	63,587,590	0.236224
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	10,187,667	44,343,502	0.229744
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy	1,779,391	2,385,974	0.745771
12.	Respiratory Therapy	2,833,430	10,521,826	0.269291
13.	Physical Therapy	4,328,673	10,395,615	0.416394
14.	Occupational Therapy	792,646	1,237,040	0.640760
15.	Speech Pathology	296,508	680,817	0.435518
16.	EKG	20,913,270	67,275,340	0.310861
17.	EEG	882,081	1,907,943	0.462320
18.	Med. / Surg. Supplies	2,996,194	18,516,109	0.161816
19.	Drugs Charged to Patients	15,483,563	68,827,936	0.224960
20.	Renal Dialysis	3,839,377	8,292,783	0.462978
21.	Ambulance			
22.	Pulmonary Function	392,437	2,143,168	0.183111
23.	Wound Care Center	267,248	278,208	0.960605
23.01	Diabetes Center	698,744	6,938,248	0.100709
23.02	Clinical Nutrition (Services)	451,046	611,527	0.737573
23.03	S.C.O.R.E.	113,265	462,012	0.245156
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	13,140,377	23,400,858	0.561534
26.	Treatment/Observ Beds (Non-distinct)	491,648	603,471	0.814700
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	35,209,141	52,422	671.65
28.				
29.				
30.				
31.	Intensive Care Unit	5,380,890	4,086	1,316.91
32.	Coronary Care Unit	4,387,879	2,867	1,530.48
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,993,941	6,439	464.97

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

PRELIMINARY

Medicare Provider Number: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-03 To: 04-30-04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	6,717		6,717
Newborn Days	3,542		3,542
Total Inpatient Revenue	30,397,511	(805)	30,396,706
Ancillary Revenue	20,841,839	(805)	20,841,034
Routine Revenue	9,555,672		9,555,672
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:**

The Column 27 cost instead of the Column 25 cost was used to calculate the filed cost-to-charge ratio for Renal Dialysis.

Occupational Therapy and Diabetes Center charges on OHF Supplement No. 2 are greater than the filed W/S C charges.

Disallowed \$805 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.