

# 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: 10-01-03	To: 09-30-04	

**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 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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II _____	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I XXXX Psych	<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 10-01-03 and ending 09-30-04 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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

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	207	75,762		69,594	91.86%		16,055	4.81	
2.	Psychiatry	32	11,712		8,108	69.23%		1,142	7.10	
3.	Rehabilitation Unit	42	15,372		13,612	88.55%		970	14.03	
4.										
5.	Intensive Care Unit	10	3,660		3,248	88.74%				
6.	Coronary Care Unit	15	5,490		4,398	80.11%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	26	9,490		2,223	23.42%				
16.	Total	332	121,486		101,183	83.29%		18,167	5.45	
17.	Observation Bed Days				607					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatry				2,373			362	6.56	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				2,373	2.35%		362	6.56	

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-Psychiatric	Period Covered by Statement:	From: 10-01-03 To: 09-30-04

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	0.339716	6,263			2,128		
2.	Recovery Room	0.460888						
3.	Delivery and Labor Room	0.796633						
4.	Anesthesiology	0.207040	432			89		
5.	Radiology - Diagnostic	0.411013	21,912			9,006		
6.	FCC Clinics	0.302201	107			32		
7.	Radioisotope	0.195012	66,170			12,904		
8.	Laboratory	0.187596	454,550			85,272		
9.	Blood							
10.	Blood - Administration	0.335165	773			259		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.243401	5,890			1,434		
13.	Physical Therapy	0.350062	8,596			3,009		
14.	Occupational Therapy	0.252860	1,815			459		
15.	Speech Pathology	0.461502	727			336		
16.	EKG	0.084456	122,991			10,387		
17.	EMG	0.244112	3,827			934		
18.	Med. / Surg. Supplies	0.333337						
19.	Drugs Charged to Patients	0.283959	153,373			43,552		
20.	Renal Dialysis	0.544615						
21.	Lithotripsy	0.406884						
22.	MRI	0.145142	21,564			3,130		
23.	CT Scan	0.073233	22,251			1,630		
23.01	Ultrasound	0.238405	21,524			5,131		
23.02	Special Procedures	0.296863						
23.03	ASC (Non-distinct Part)	0.472694	530			251		
23.04	Psych Services	0.636416	742			472		
23.05	Retinal Vascular	0.635196						
23.06	Pulmonary Function	0.129267	1,164			150		
23.07	Hemodynamics	0.351103						
23.08								
23.09	Wound Clinic	0.466824	280			131		
<b>Outpatient Service Cost Centers</b>								
24.	Diabetes Ed Clinic							
25.	Emergency	0.265737	292,281			77,670		
26.	Observation Beds (Non-distinct Part)	0.658413						
27.	<b>Total</b>		1,207,762			258,366		

\* 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-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

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)	\$ 556.35	\$ 556.35	\$ 552.90	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		2,373		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 1,320,219	\$	\$
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)	\$	\$ 1,320,219	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,147.76		\$
9.	Coronary Care Unit	\$ 1,300.40		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 669.26		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 258,366
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 1,578,585</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-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-03 To: 09-30-04

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.	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:	14-0191	Public Aid Provider Number:	8006
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 10-01-03 To: 09-30-04

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									
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										
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>			Days	Per Diem	Days					
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**

Medicare Provider Number: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

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)	1,578,585		
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>	1,578,585		
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)	1,207,762
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatry	3,156,152
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	4,363,914
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,785,329
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: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

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)	1,578,585		
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)	1,578,585		
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>	1,578,585		

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-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

**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)	2,785,329
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
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)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	<b>Total (Sum of Lines 1 - 3)</b>							

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

OHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

**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 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-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

**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	16,174,010	47,610,319	0.339716
2.	Recovery Room	1,518,646	3,295,046	0.460888
3.	Delivery and Labor Room	4,141,352	5,198,568	0.796633
4.	Anesthesiology	1,366,811	6,601,677	0.207040
5.	Radiology - Diagnostic	10,922,833	26,575,387	0.411013
6.	FCC Clinics	12,698,224	42,019,171	0.302201
7.	Radioisotope	2,051,657	10,520,657	0.195012
8.	Laboratory	12,497,093	66,617,122	0.187596
9.	Blood			
10.	Blood - Administration	2,061,299	6,150,104	0.335165
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,988,959	12,279,965	0.243401
13.	Physical Therapy	7,588,752	21,678,318	0.350062
14.	Occupational Therapy	1,715,233	6,783,338	0.252860
15.	Speech Pathology	688,415	1,491,685	0.461502
16.	EKG	1,710,361	20,251,556	0.084456
17.	EMG	859,348	3,520,297	0.244112
18.	Med. / Surg. Supplies	2,766,856	8,300,478	0.333337
19.	Drugs Charged to Patients	11,578,626	40,775,734	0.283959
20.	Renal Dialysis	1,142,463	2,097,746	0.544615
21.	Lithotripsy	498,279	1,224,621	0.406884
22.	MRI	1,926,342	13,272,115	0.145142
23.	CT Scan	1,561,819	21,326,601	0.073233
23.01	Ultrasound	1,720,592	7,217,085	0.238405
23.02	Special Procedures	2,599,092	8,755,200	0.296863
23.03	ASC (Non-distinct Part)	2,175,000	4,601,290	0.472694
23.04	Psych Services	1,113,648	1,749,874	0.636416
23.05	Retinal Vascular	1,097,471	1,727,767	0.635196
23.06	Pulmonary Function	143,195	1,107,745	0.129267
23.07	Hemodynamics	6,360,532	18,115,837	0.351103
23.08				
23.09	Wound Clinic	1,421,269	3,044,548	0.466824
<b>Outpatient Ancillary Centers</b>				
24.	Diabetes Ed Clinic			
25.	Emergency	8,072,890	30,379,280	0.265737
26.	Observation Beds (Non-distinct Part)	347,529	527,828	0.658413
<b>Routine Service Cost Centers</b>				
			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	39,056,242	70,201	556.35
28.	Psychiatry	4,510,876	8,108	556.35
29.	Rehabilitation Unit	7,526,069	13,612	552.90
30.				
31.	Intensive Care Unit	3,727,923	3,248	1,147.76
32.	Coronary Care Unit	5,719,172	4,398	1,300.40
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,487,762	2,223	669.26

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

PRELIMINARY

Medicare Provider Number: 14-0191	Public Aid Provider Number: 8006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-03 To: 09-30-04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,373		2,373
Newborn Days			
Total Inpatient Revenue	4,363,914		4,363,914
Ancillary Revenue	1,207,762		1,207,762
Routine Revenue	3,156,152		3,156,152
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.

Medicaid Psych days filed are the same as in the prior year, 09/30/2003.

Radiology-Therapeutic charges on filed report are MRI.

Reclassified EEG charges as EMG. Determined per cost-to-charge ratio.

Reclassified Ambulance charges as Special Procedures. Determined per cost-to-charge ratio.