

# 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: St. James Hospital & Health Centers		Medicare Provider Number: 14-0172	
Street: 20201 S. Crawford Avenue		Public Aid Provider Number: 31000	
City: Olympia Fields	State: Illinois	Zip: 60461	
Period Covered by Statement:	From: 01-01-04	To: 12-31-04	

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" 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)	<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 type="checkbox"/> Medicaid Hospital	<input checked="" type="checkbox"/> Medicaid Sub II Rehabilitation	<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)) St. James Hospital & Health C 31000 for the cost report beginning 01-01-04 and ending 12-31-04 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

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	331	112,779		79,680	70.65%		21,649	4.06	
2.	Psychiatry	2	420							
3.	Rehabilitation Unit	18	6,570		5,217	79.41%		559	9.33	
4.										
5.	Intensive Care Unit	36	13,176		8,306	63.04%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	41	15,006		4,407	29.37%				
16.	Total	428	147,951		97,610	65.97%		22,208	4.20	
17.	Observation Bed Days				2,834					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatry									
3.	Rehabilitation Unit				174			16	10.88	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				174	0.18%		16	10.88	

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: <b>14-0172</b>	Public Aid Provider Number: <b>31000</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>01-01-04</b> To: <b>12-31-04</b>

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) <b>(1)</b>	Total Billed I/P Charges (Gross) for Health Care Program Patients <b>(2)</b>	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) <b>(5)</b>	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients <b>(3)</b>	Total Billed O/P Charges (Gross) for Health Care Program Patients <b>(4)</b>		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) <b>(6)</b>	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) <b>(7)</b>
1.	Operating Room	0.464302	2,389			1,109		
2.	Recovery Room	0.318358	386			123		
3.								
4.	Anesthesiology	0.108972	294			32		
5.	Radiology- Diagnostic	0.307296	6,100			1,875		
6.	Radiology- Therapeutic	0.467765	152			71		
7.	Radioisotope	0.309080	1,418			438		
8.	Laboratory	0.268294	22,809			6,120		
9.								
10.								
11.								
12.	Respiratory Therapy	0.233934	8,315			1,945		
13.	Physical Therapy	0.440763	103,509			45,623		
14.	Occupational Therapy	0.338480						
15.	Speech Pathology	0.420697						
16.	EKG	0.149702	2,890			433		
17.	EEG	0.172622	174			30		
18.	Med. / Surg. Supplies	0.143022	20,113			2,877		
19.	Drugs Charged to Patients	0.252803	34,384			8,692		
20.	Renal Dialysis	0.416471	2,763			1,151		
21.								
22.	TCT Scan	0.058497	4,102			240		
23.	MRI	0.142895	1,584			226		
23.01								
23.02								
23.03	Cath Lab	0.269336	833			224		
23.04								
23.05								
23.06	ASC (Nondistinct Part)	0.623808						
23.07								
23.08	Wound Care	0.170391						
23.09	Sleep Lab	0.213467						
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	8.112432						
25.	Emergency	0.336521	3,546			1,193		
26.	Observation Beds	0.499723						
27.	<b>Total</b>		215,761			72,402		

\* 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

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)	\$ 768.95	\$	\$ 519.51	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			174	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 90,395	\$
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)	\$	\$	\$ 90,395	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,349.22		\$
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 644.83		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 72,402
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 162,797</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> 14-0172		<b>Public Aid Provider Number:</b> 31000	
<b>Program:</b> Medicaid-Rehabilitation		<b>Period Covered by Statement:</b> From: 01-01-04 To: 12-31-04	

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.	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.	Clinic										
14.	Emergency										
15.	Observation Beds										
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>14-0172</b>	Public Aid Provider Number: <b>31000</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>01-01-04</b> To: <b>12-31-04</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									
2.	Recovery Room									
3.										
4.	Anesthesiology	4,567,792	21,270,917	0.214744	294			63		
5.	Radiology- Diagnostic	54,708	28,882,941	0.001894	6,100			12		
6.	Radiology- Therapeutic									
7.	Radioisotope									
8.	Laboratory	92,336	65,321,346	0.001414	22,809			32		
9.										
10.										
11.										
12.	Respiratory Therapy									
13.	Physical Therapy	33,660	7,530,916	0.004470	103,509			463		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.										
22.	TCT Scan									
23.	MRI	2,583	11,448,543	0.000226	1,584					
23.01										
23.02										
23.03	Cath Lab									
23.04										
23.05										
23.06	ASC (Nondistinct Part)									
23.07										
23.08	Wound Care	33,660	210,082	0.160223						
23.09	Sleep Lab									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	48,000	46,276,771	0.001037	3,546			4		
26.	Observation Beds									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	315,997	82,514	3.83						
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>							574		

\* 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

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)	162,797		
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)	574		
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>	163,371		
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)	215,761
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatry	
	C. Rehabilitation Unit	202,864
	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>	418,625
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	255,254
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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

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)	163,371		
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)	163,371		
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>	163,371		

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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

**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)	255,254
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(2A)	(2B)	(3A)	(3B)	(4A)	(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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

**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 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: 14-0172	Public Aid Provider Number: 31000
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01-01-04 To: 12-31-04

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	28,216,083	60,770,973	0.464302
2.	Recovery Room	2,709,217	8,509,966	0.318358
3.				
4.	Anesthesiology	2,317,929	21,270,917	0.108972
5.	Radiology- Diagnostic	8,875,599	28,882,941	0.307296
6.	Radiology- Therapeutic	2,404,334	5,140,049	0.467765
7.	Radioisotope	4,295,031	13,896,179	0.309080
8.	Laboratory	17,525,341	65,321,346	0.268294
9.				
10.				
11.				
12.	Respiratory Therapy	4,597,826	19,654,347	0.233934
13.	Physical Therapy	3,319,350	7,530,916	0.440763
14.	Occupational Therapy	834,859	2,466,492	0.338480
15.	Speech Pathology	285,753	679,237	0.420697
16.	EKG	2,994,265	20,001,556	0.149702
17.	EEG	234,163	1,356,506	0.172622
18.	Med. / Surg. Supplies	5,087,648	35,572,383	0.143022
19.	Drugs Charged to Patients	14,526,766	57,462,806	0.252803
20.	Renal Dialysis	1,198,075	2,876,733	0.416471
21.				
22.	TCT Scan	2,088,956	35,710,756	0.058497
23.	MRI	1,635,944	11,448,543	0.142895
23.01				
23.02				
23.03	Cath Lab	12,798,154	47,517,360	0.269336
23.04				
23.05				
23.06	ASC (Nondistinct Part)	3,056,147	4,899,176	0.623808
23.07				
23.08	Wound Care	35,796	210,082	0.170391
23.09	Sleep Lab	254,558	1,192,494	0.213467
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	526,797	64,937	8.112432
25.	Emergency	15,573,127	46,276,771	0.336521
26.	Observation Beds	1,859,898	3,721,856	0.499723
<b>Routine Service Cost Centers</b>				
27.	Adults and Pediatrics	63,449,020	82,514	768.95
28.	Psychiatry			
29.	Rehabilitation Unit	2,710,271	5,217	519.51
30.				
31.	Intensive Care Unit	11,206,653	8,306	1,349.22
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,841,771	4,407	644.83

