

# Hospital Statement of Cost

Illinois Department of Public Aid, Office of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

**General Information**

**REVISED PRELIMINARY as of 09/12/2007.**

Name of Hospital: Provena Covenant Medical Center		Medicare Provider Number: 14-0113	
Street: 1400 West Park Street		Public Aid Provider Number: 21001	
City: Urbana	State: Illinois	Zip: 61801	
Period Covered by Statement:	From: 01-01-05	To: 12-31-05	

**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 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)) Provena Covenant Medical C, 21001 for the cost report beginning 01-01-05 and ending 12-31-05 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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

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	115	42,123	501	24,882	59.07%		9,716	3.05	
2.	Rehabilitation Unit	25	9,125	34	4,439	48.65%		423	10.49	
3.	Psychiatric Unit	18	6,570		4,313	65.65%		820	5.26	
4.										
5.	Intensive Care Unit	15	5,475		3,461	63.21%				
6.	Coronary Care Unit									
7.	Neonatal Intensive Care	12	4,380		1,285	29.34%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	21	7,665		2,010	26.22%				
16.	Total	206	75,338	535	40,390	53.61%		10,959	3.50	
17.	Observation Bed Days				1,261					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				3,699			1,569	3.22	
2.	Rehabilitation Unit									
3.	Psychiatric Unit									
4.										
5.	Intensive Care Unit				298					
6.	Coronary Care Unit									
7.	Neonatal Intensive Care				1,053					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,137					
16.	Total				6,187	15.32%		1,569	3.22	

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

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number:	14-0113	Public Aid Provider Number:	21001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-05 To: 12-31-05

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	0.384115	1,687,454			648,176		
2.	Recovery Room							
3.	Delivery and Labor Room	0.722127	1,521,804			1,098,936		
4.	Anesthesiology	0.101298	465,289			47,133		
5.	Radiology - Diagnostic	0.210475	723,697			152,320		
6.	Radiology - Therapeutic	0.232432	44,917			10,440		
7.	Nuclear Medicine							
8.	Laboratory	0.197292	2,531,029			499,352		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.160283	1,867,268			299,291		
13.	Physical Therapy	0.346153	42,602			14,747		
14.	Occupational Therapy	0.215444	36,450			7,853		
15.	Speech Pathology	0.219194	11,539			2,529		
16.	EKG	0.130143	48,569			6,321		
17.	EEG	0.278726	22,025			6,139		
18.	Med. / Surg. Supplies	0.208041	1,411,081			293,563		
19.	Drugs Charged to Patients	0.193034	3,082,487			595,025		
20.	Renal Dialysis	1.196733	17,674			21,151		
21.	Ambulance	0.776622						
22.	CT Scan	0.228525	710,782			162,431		
23.	Gastrointestinal Services	0.200811	109,234			21,935		
23.01	Other Cardiology	0.183040	1,984,766			363,292		
23.02								
23.03								
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.213239	838,985			178,904		
26.	Observation Beds (Non-distinct Par	0.495819	53,047			26,302		
27.	<b>Total</b>		17,210,699			4,455,840		

\* 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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Psychiatric Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 774.70	\$ 1,013.05	\$ 631.84	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	3,699			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 2,865,615	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 4.30	\$	\$	\$
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)	\$ 2,865,615	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,572.00	298	\$ 468,456
9.	Coronary Care Unit	\$		\$
10.	Neonatal Intensive Care	\$ 1,294.29	1,053	\$ 1,362,887
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 242.98	1,137	\$ 276,268
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 4,455,840
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 9,429,066</b>

**Hospital Statement of Cost**  
**Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**  
 REVISED PRELIMINARY as of 09/12/2007.

<b>Medicare Provider Number:</b> 14-0113	<b>Public Aid Provider Number:</b> 21001
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-05 To: 12-31-05

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.	Rehabilitation Unit						
4.	Psychiatric Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal Intensive Care						
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 (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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number:	14-0113	Public Aid Provider Number:	21001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-05 To: 12-31-05

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	2,218,386	10,482,615	0.211625	465,289			98,467		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	107,450	1,480,706	0.072567	48,569			3,525		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	CT Scan									
23.	Gastrointestinal Services									
23.01	Other Cardiology									
23.02										
23.03										
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	29,058	27,588,927	0.001053	838,985			883		
26.	Observation Beds (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Psychiatric Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal Intensive Care									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							102,875		

\* 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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

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)	9,429,066		
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)	102,875		
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>	9,531,941		
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)	17,210,699
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,424,422
	B. Rehabilitation Unit	
	C. Psychiatric Unit	
	D.	
	E. Intensive Care Unit	720,212
	F. Coronary Care Unit	
	G. Neonatal Intensive Care	1,362,301
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	424,053
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	22,141,687
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	12,609,746
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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

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)	9,531,941		
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)	9,531,941		
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>	9,531,941		

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**

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

**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)	12,609,746
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.	<b>Total (Sum of Lines 1 - 3)</b>							

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

OHF Supplement No. 1

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

**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 Rehabilitation Unit	Sub II Psychiatric Unit	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 Rehabilitation Unit	Sub II Psychiatric Unit	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 Rehabilitation Unit	Sub II Psychiatric Unit	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)	20,780,866			
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	20,380,458			
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	400,408			
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	25,642			
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	501			
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	799.22			
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	794.81			
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	4.41			
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))	4.30			
7. Private room cost differential adjustment (Line 2B X Line 6)	2,154			
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)	20,253,003			
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)	774.70			

**Hospital Statement of Cost  
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

**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	17,827,860	46,412,813	0.384115
2.	Recovery Room			
3.	Delivery and Labor Room	2,958,121	4,096,398	0.722127
4.	Anesthesiology	1,061,869	10,482,615	0.101298
5.	Radiology - Diagnostic	4,344,199	20,639,959	0.210475
6.	Radiology - Therapeutic	2,509,568	10,797,009	0.232432
7.	Nuclear Medicine			
8.	Laboratory	7,186,340	36,424,935	0.197292
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,352,534	14,677,402	0.160283
13.	Physical Therapy	1,218,385	3,519,786	0.346153
14.	Occupational Therapy	445,654	2,068,536	0.215444
15.	Speech Pathology	154,048	702,794	0.219194
16.	EKG	192,704	1,480,706	0.130143
17.	EEG	139,303	499,784	0.278726
18.	Med. / Surg. Supplies	2,266,247	10,893,285	0.208041
19.	Drugs Charged to Patients	6,628,389	34,338,020	0.193034
20.	Renal Dialysis	230,650	192,733	1.196733
21.	Ambulance	3,260,877	4,198,794	0.776622
22.	CT Scan	1,836,792	8,037,590	0.228525
23.	Gastrointestinal Services	2,004,389	9,981,467	0.200811
23.01	Other Cardiology	8,873,885	48,480,592	0.183040
23.02				
23.03				
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	5,883,026	27,588,927	0.213239
26.	Observation Beds (Non-distinct Part)	922,008	1,859,565	0.495819
<b>Routine Service Cost Centers</b>				
27.	Adults and Pediatrics		<b>Total Days</b>	<b>Per Diem</b>
28.	Rehabilitation Unit	4,496,944	4,439	See Supplement 1 1,013.05
29.	Psychiatric Unit	2,725,147	4,313	631.84
30.				
31.	Intensive Care Unit	5,440,675	3,461	1,572.00
32.	Coronary Care Unit			
33.	Neonatal Intensive Care	1,663,162	1,285	1,294.29
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	488,398	2,010	242.98

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

REVISED PRELIMINARY as of 09/12/2007.

Medicare Provider Number: 14-0113	Public Aid Provider Number: 21001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-05 To: 12-31-05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,216	834	5,050
Newborn Days	751	386	1,137
Total Inpatient Revenue	21,130,303	1,011,384	22,141,687
Ancillary Revenue	16,426,975	783,724	17,210,699
Routine Revenue	4,703,328	227,660	4,930,988
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.

Used prior years Nursery Beds Available to determine current year Total Beds Available & Total Bed Days Available.

adjusting for prior leap year.

Included 2 Observation Room Days for SubProvider II with total on W/S S-3, line 14.01 (Psych).

This Preliminary Revision is due to changes made by Provena-Anne Little-Director of Reimbursement on 08/16/2007.