

# 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: Rush University Medical Center		Medicare Provider Number: 14-0119	
Street: 1753 West Congress Parkway		Public Aid Provider Number: 3048	
City: Chicago	State: Illinois	Zip: 60612	
Period Covered by Statement:	From: 07-01-04	To: 06-30-05	

**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 checked="" type="checkbox"/> Medicaid Hospital XXXX XXXX	<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)) Rush University Medical Cent 3048 for the cost report beginning 07-01-04 and ending 06-30-05 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

PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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	362	129,676	89,224	99,920	77.05%		28,264	4.16	
2.	Rehabilitation Unit	40	14,600	4,064	12,577	86.14%		1,279	9.83	
3.	Psychiatric Unit	91	33,215	14,439	20,760	62.50%		1,931	10.75	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU	39	12,787		8,912	69.70%				
8.	Medical ICU	51	18,615		8,875	47.68%				
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	21	7,665		3,885	50.68%				
16.	Total	604	216,558	107,727	154,929	71.54%		31,474	4.80	
17.	Observation Bed Days				904					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			12,783	14,901			4,337	4.04	
2.	Rehabilitation Unit									
3.	Psychiatric Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU				651					
8.	Medical ICU				1,976					
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,448					
16.	Total			12,783	18,976	12.25%		4,337	4.04	

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:	14-0119	Public Aid Provider Number:	3048
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-04 To: 06-30-05

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	0.326593	10,681,166			3,488,394		
2.	Recovery Room	0.271912	413,305			112,383		
3.	Delivery and Labor Room	0.497029	5,037,983			2,504,024		
4.	Anesthesiology	0.138337	3,338,222			461,800		
5.	Radiology - Diagnostic	0.236629	13,583,543			3,214,260		
6.	Radiology - Therapeutic	0.215299	549,906			118,394		
7.	Radioisotope	0.241353	495,932			119,695		
8.	Laboratory	0.239463	21,077,031			5,047,169		
9.	Blood							
10.	Blood - Administration	0.303108	9,982,430			3,025,754		
11.	Intravenous Therapy	0.187829	1,717,200			322,540		
12.	Respiratory Therapy	0.355554	2,039,586			725,183		
13.	Physical Therapy	0.350751	401,548			140,843		
14.	Occupational Therapy	0.563417	179,486			101,125		
15.	Speech Pathology	0.760089	70,338			53,463		
16.	EKG	0.246585	3,142,618			774,922		
17.	EEG	0.444381	1,016,210			451,584		
18.	Med. / Surg. Supplies	0.076299	3,861,162			294,603		
19.	Drugs Charged to Patients	0.195625	24,592,154			4,810,840		
20.	Renal Dialysis	2.289536						
21.	Renal Dialysis Inpatient	0.318550	1,257,161			400,469		
22.	Behavioral Health	0.828366						
23.	Kidney Acquisition [per W/S D-6]	0.433320	2,286,635			990,845		
23.01	Liver Acquisition [per W/S D-6]	0.466625	1,198,211			559,115		
23.02	Heart Acquisition [per W/S D-6]	0.840806	10,049			8,449		
23.03	Pancreas Acquisition [per W/S D-6]	0.758833	76,490			58,043		
23.04	Psych Day Hospital	1.843556						
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.513551	23,593			12,116		
25.	Emergency	0.429620	2,212,392			950,488		
26.	Observation Beds (Non-distinct Par	0.153119						
27.	<b>Total</b>		109,244,351			28,746,501		

\* 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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)	\$ 866.23	\$ 650.32	\$ 845.65	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	14,901			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 12,907,693	\$	\$	\$
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)	12,783			
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)	\$ 12,907,693	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$		\$
10.	Surgical ICU	\$ 2,017.32	651	\$ 1,313,275
11.	Medical ICU	\$ 1,854.14	1,976	\$ 3,663,781
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 547.01	1,448	\$ 792,070
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 28,746,501
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 47,423,320</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> 14-0119	<b>Public Aid Provider Number:</b> 3048
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07-01-04 To: 06-30-05

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.	Surgical ICU						
9.	Medical ICU						
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

PRELIMINARY

Medicare Provider Number: <b>14-0119</b>	Public Aid Provider Number: <b>3048</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>07-01-04</b> To: <b>06-30-05</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.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Renal Dialysis Inpatient									
22.	Behavioral Health									
23.	Kidney Acquisition [per W/S D-6]									
23.01	Liver Acquisition [per W/S D-6]									
23.02	Heart Acquisition [per W/S D-6]									
23.03	Pancreas Acquisition [per W/S D-6]									
23.04	Psych Day Hospital									
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency									
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.	Surgical ICU									
34.	Medical ICU									
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**

<b>Medicare Provider Number:</b> 14-0119		<b>Public Aid Provider Number:</b> 3048	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 07-01-04 To: 06-30-05	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	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)	47,423,320	
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>	47,423,320	
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)	109,244,351
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	25,315,211
	B. Rehabilitation Unit	
	C. Psychiatric Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Surgical ICU	1,936,019
	H. Medical ICU	6,249,353
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	1,367,619
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	144,112,553
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	96,689,233
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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)
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)	47,423,320		
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>	47,423,320		

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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-04 To: 06-30-05

**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)	96,689,233
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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-04 To: 06-30-05

**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)				
(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**

<b>Medicare Provider Number:</b> 14-0119	<b>Public Aid Provider Number:</b> 3048
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07-01-04 To: 06-30-05

**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	97,038,926	297,124,936	0.326593
2.	Recovery Room	3,730,713	13,720,273	0.271912
3.	Delivery and Labor Room	8,227,746	16,553,844	0.497029
4.	Anesthesiology	8,658,020	62,586,262	0.138337
5.	Radiology - Diagnostic	41,674,266	176,116,119	0.236629
6.	Radiology - Therapeutic	7,466,719	34,680,753	0.215299
7.	Radioisotope	4,857,375	20,125,575	0.241353
8.	Laboratory	77,642,125	324,234,351	0.239463
9.	Blood			
10.	Blood - Administration	18,183,176	59,989,150	0.303108
11.	Intravenous Therapy	2,320,755	12,355,680	0.187829
12.	Respiratory Therapy	8,951,110	25,175,086	0.355554
13.	Physical Therapy	5,300,489	15,111,847	0.350751
14.	Occupational Therapy	3,796,615	6,738,557	0.563417
15.	Speech Pathology	2,219,516	2,920,075	0.760089
16.	EKG	13,084,089	53,061,177	0.246585
17.	EEG	4,464,002	10,045,432	0.444381
18.	Med. / Surg. Supplies	2,080,685	27,270,225	0.076299
19.	Drugs Charged to Patients	48,617,679	248,524,882	0.195625
20.	Renal Dialysis	1,336,821	583,883	2.289536
21.	Renal Dialysis Inpatient	2,053,985	6,447,916	0.318550
22.	Behavioral Health	9,989,359	12,059,109	0.828366
23.	Kidney Acquisition [per W/S D-6]	6,288,052	14,511,338	0.433320
23.01	Liver Acquisition [per W/S D-6]	3,944,254	8,452,725	0.466625
23.02	Heart Acquisition [per W/S D-6]	838,948	997,790	0.840806
23.03	Pancreas Acquisition [per W/S D-6]	290,214	382,448	0.758833
23.04	Psych Day Hospital	4,124,703	2,237,362	1.843556
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	14,525,486	28,284,406	0.513551
25.	Emergency	18,559,619	43,200,087	0.429620
26.	Observation Beds (Non-distinct Part)	765,254	4,997,787	0.153119
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	87,337,256	100,824	866.23
28.	Rehabilitation Unit	8,179,089	12,577	650.32
29.	Psychiatric Unit	17,555,782	20,760	845.65
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Surgical ICU	17,978,335	8,912	2,017.32
34.	Medical ICU	16,455,485	8,875	1,854.14
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,125,137	3,885	547.01

