

# Hospital Statement of Cost

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

**General Information**

**PRELIMINARY**

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

**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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) XXXX XXXX	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

**Type of Hospital**

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

**Health Care Program**

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law**

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):**

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Sherman Hospital 5006 for the cost report beginning 05-01-04 and ending 04-30-05 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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-04 To: 04-30-05

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	311	113,515		49,755	43.83%		16,617	3.35	
2.										
3.										
4.										
5.	Intensive Care Unit	18	6,570		3,146	47.88%				
6.	Coronary Care Unit	10	3,650		2,773	75.97%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	47	17,155		6,667	38.86%				
16.	Total	386	140,890		62,341	44.25%		16,617	3.35	
17.	Observation Bed Days				763					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				5,992			2,564	2.48	
2.										
3.										
4.										
5.	Intensive Care Unit				241					
6.	Coronary Care Unit				117					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				3,566					
16.	Total				9,916	15.91%		2,564	2.48	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

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

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	0.385915	1,677,036			647,193		
2.	Recovery Room	0.444317	172,521			76,654		
3.	Delivery and Labor Room	0.472861	2,966,965			1,402,962		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.217053	1,876,671			407,337		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.205513	3,239,548			665,769		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	0.786309	3,439			2,704		
12.	Respiratory Therapy	0.276943	598,712			165,809		
13.	Physical Therapy	0.413263	88,850			36,718		
14.	Occupational Therapy	0.384128	27,401			10,525		
15.	Speech Pathology	0.404365	28,916			11,693		
16.	EKG	0.277010	972,441			269,376		
17.	EEG	0.494993	15,927			7,884		
18.	Med. / Surg. Supplies	0.185440	674,224			125,028		
19.	Drugs Charged to Patients	0.202211	8,551,582			1,729,224		
20.	Renal Dialysis	0.591531	134,007			79,269		
21.	Ambulance							
22.	Pulmonary Function	0.196644	224,085			44,065		
23.	Wound Care Center	1.135185	117			133		
23.01	Diabetes Center	1.813076	5,912			10,719		
23.02	Clinical Nutrition (Services)	0.730572	226,632			165,571		
23.03	S.C.O.R.E.	0.295069						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.479275	770,656			369,356		
26.	Treatment/Observ Beds (Non-distin	0.640141						
27.	<b>Total</b>		22,255,642			6,227,989		

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

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

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 721.53	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	5,992			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 4,323,408	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 4,323,408	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,497.50	241	\$ 360,898
9.	Coronary Care Unit	\$ 1,704.67	117	\$ 199,446
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 476.80	3,566	\$ 1,700,269
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 6,227,989
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 12,812,010</b>

**Hospital Statement of Cost  
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program  
PRELIMINARY**

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

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.							
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.							
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Treatment/Observ Beds (Non-dis										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

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

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	30,000	63,568,347	0.000472	1,677,036			792		
2.	Recovery Room									
3.	Delivery and Labor Room	624,480	10,878,113	0.057407	2,966,965			170,325		
4.	Anesthesiology									
5.	Radiology - Diagnostic	67,744	76,185,206	0.000889	1,876,671			1,668		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	24,000	50,554,195	0.000475	3,239,548			1,539		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	8,750	11,297,047	0.000775	598,712			464		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	60,000	70,181,968	0.000855	972,441			831		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	48,000	6,605,117	0.007267	134,007			974		
21.	Ambulance									
22.	Pulmonary Function									
23.	Wound Care Center									
23.01	Diabetes Center	24,000	369,321	0.064984	5,912			384		
23.02	Clinical Nutrition (Services)									
23.03	S.C.O.R.E.	400	658,015	0.000608						
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	4,210,428	30,420,573	0.138407	770,656			106,664		
26.	Treatment/Observ Beds (Non-distinct)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	146,946	6,667	22.04	3,566			78,595		
37.	<b>Total</b>							362,236		

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost  
Computation of Lesser of Reasonable Cost or Customary Charges**

**PRELIMINARY**

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

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)	12,812,010		
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)	362,236		
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	13,174,246		
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)	22,255,642
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	6,961,792
	B.	
	C.	
	D.	
	E. Intensive Care Unit	703,298
	F. Coronary Care Unit	348,723
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	3,696,565
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	33,966,020
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	20,791,774
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

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

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)	13,174,246		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	13,174,246		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF Page 9, Part III, Line 4, Cols. 2B, 3B, & 4B)			
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With HCFA Pub. 15-II, Sec. 115.2 (B)			
6.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	13,174,246		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

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

**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)	20,791,774
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: 14-0030	Public Aid Provider Number: 5006
Program: Medicaid-Hospital	Period Covered by Statement: From: 05-01-04 To: 04-30-05

**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	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

**Part C. Program Cost**

	General Service	Sub I	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I	Sub II	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To OHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 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> 14-0030	<b>Public Aid Provider Number:</b> 5006
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 05-01-04 To: 04-30-05

**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	24,531,963	63,568,347	0.385915
2.	Recovery Room	4,713,063	10,607,430	0.444317
3.	Delivery and Labor Room	5,143,838	10,878,113	0.472861
4.	Anesthesiology			
5.	Radiology - Diagnostic	16,536,260	76,185,206	0.217053
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	10,389,530	50,554,195	0.205513
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy	2,139,666	2,721,153	0.786309
12.	Respiratory Therapy	3,128,642	11,297,047	0.276943
13.	Physical Therapy	4,749,299	11,492,196	0.413263
14.	Occupational Therapy	916,523	2,385,986	0.384128
15.	Speech Pathology	338,513	837,148	0.404365
16.	EKG	19,441,105	70,181,968	0.277010
17.	EEG	809,715	1,635,810	0.494993
18.	Med. / Surg. Supplies	2,685,177	14,480,065	0.185440
19.	Drugs Charged to Patients	15,706,279	77,672,719	0.202211
20.	Renal Dialysis	3,907,131	6,605,117	0.591531
21.	Ambulance			
22.	Pulmonary Function	409,874	2,084,346	0.196644
23.	Wound Care Center	310,203	273,262	1.135185
23.01	Diabetes Center	669,607	369,321	1.813076
23.02	Clinical Nutrition (Services)	464,001	635,120	0.730572
23.03	S.C.O.R.E.	194,160	658,015	0.295069
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	14,579,824	30,420,573	0.479275
26.	Treatment/Observ Beds (Non-distinct)	550,527	860,009	0.640141
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	36,450,318	50,518	721.53
28.				
29.				
30.				
31.	Intensive Care Unit	4,711,122	3,146	1,497.50
32.	Coronary Care Unit	4,727,041	2,773	1,704.67
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	3,178,823	6,667	476.80

