

# 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: Mercy Hospital & Medical Center		Medicare Provider Number: 14-0158	
Street: 2525 South Michigan Avenue		Public Aid Provider Number: 3042	
City: Chicago	State: Illinois	Zip: 60616-2477	
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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

**Health Care Program**

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

<input type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I <small>XXXX XXXX</small> Psychiatric	<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)) Mercy Hospital & Medical Cer 3042 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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	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	244	89,060		34,012	38.19%		12,026	3.47	
2.	Psychiatric Unit	29	10,382		6,608	63.65%		1,000	6.61	
3.	Rehabilitation Unit	24	8,760		4,791	54.69%		511	9.38	
4.										
5.	Intensive Care Unit	14	5,110		3,396	66.46%				
6.	Coronary Care Unit	6	2,196		1,716	78.14%				
7.	Nursery ICU/Special Care Nursery	15	5,475		2,565	46.85%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	28	10,220		3,529	34.53%				
16.	Total	360	131,203		56,617	43.15%		13,537	3.92	
17.	Observation Bed Days				2,721					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				4,156			720	5.77	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Nursery ICU/Special Care Nursery									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				4,156	7.34%		720	5.77	

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:	14-0158	Public Aid Provider Number:	3042
Program:	Medicaid-Psychiatric	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	0.409563	541			222		
2.	Recovery Room	0.324427						
3.	Delivery and Labor Room	0.252114						
4.	Anesthesiology	0.146933						
5.	Radiology - Diagnostic	0.267157	28,676			7,661		
6.	Radiology - Therapeutic	0.137325						
7.	Nuclear Medicine	0.172323	829			143		
8.	Laboratory	0.188695	549,833			103,751		
9.	Diabetes Treatment Center							
10.	Doctors Office Center							
11.	Mercy Rheumatology Center							
12.	Respiratory Therapy	0.203810	25,853			5,269		
13.	Physical Therapy	0.340309	708			241		
14.	Occupational Therapy	0.433985	183,860			79,792		
15.	Speech Pathology	0.488964	232			113		
16.	Peds Practice							
17.	EEG	0.370352	1,552			575		
18.	Med. / Surg. Supplies	0.779050	907			707		
19.	Drugs Charged to Patients	0.353169	513,804			181,460		
20.	Renal Dialysis	0.206362	10,944			2,258		
21.	Ambulance							
22.	G.I. Lab	0.264063						
23.	MRI Center	0.204377	5,040			1,030		
23.01	Pulmonary Rehab							
23.02	ASC (Non-distinct Part)	5.301703						
23.03	Urology Services							
23.04	Industrial Nursing							
23.05	Audiology	2.043419						
23.06	Electrodiagnosis [EMG]	0.140609						
23.07	Cardiovascular Labs	0.227060	67,694			15,371		
23.08	Mercy Eye Center	0.681556						
23.09	Wound Management	0.315138						
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.669173						
25.	Emergency	0.288592	406,746			117,384		
26.	Observation Beds (Non-distinct Part)	1.007608						
27.	<b>Total</b>		1,797,219			515,977		

\* 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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	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 Psychiatric Unit	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 852.16	\$ 548.85	\$ 556.08	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		4,156		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 2,281,021	\$	\$
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)	\$	\$ 2,281,021	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,443.20		\$
9.	Coronary Care Unit	\$ 1,195.55		\$
10.	Nursery ICU/Special Care Nursery	\$ 646.68		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 111.43		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 515,977
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 2,796,998</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> 14-0158	<b>Public Aid Provider Number:</b> 3042
<b>Program:</b> Medicaid-Psychiatric	<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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Nursery ICU/Special Care Nurse						
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

PRELIMINARY

Medicare Provider Number: <b>14-0158</b>	Public Aid Provider Number: <b>3042</b>
Program: <b>Medicaid-Psychiatric</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.	Nuclear Medicine									
8.	Laboratory									
9.	Diabetes Treatment Center									
10.	Doctors Office Center									
11.	Mercy Rheumatology Center									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	Peds Practice									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	G.I. Lab									
23.	MRI Center									
23.01	Pulmonary Rehab									
23.02	ASC (Non-distinct Part)									
23.03	Urology Services									
23.04	Industrial Nursing									
23.05	Audiology									
23.06	Electrodiagnosis [EMG]									
23.07	Cardiovascular Labs									
23.08	Mercy Eye Center									
23.09	Wound Management									
<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.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Nursery ICU/Special Care Nursery									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>									

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

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

**PRELIMINARY**

<b>Medicare Provider Number:</b> 14-0158		<b>Public Aid Provider Number:</b> 3042	
<b>Program:</b> Medicaid-Psychiatric		<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)	2,796,998	
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>	2,796,998	
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%	

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	1,797,219
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	4,275,942
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Nursery ICU/Special Care Nursery	
	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>	6,073,161
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	3,276,163
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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	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)	2,796,998		
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)	2,796,998		
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>	2,796,998		

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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	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)	3,276,163
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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	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 Psychiatric Unit	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 Psychiatric Unit	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 Psychiatric Unit	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**

<b>Medicare Provider Number:</b> 14-0158	<b>Public Aid Provider Number:</b> 3042
<b>Program:</b> Medicaid-Psychiatric	<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	12,496,505	30,511,775	0.409563
2.	Recovery Room	846,700	2,609,829	0.324427
3.	Delivery and Labor Room	4,611,771	18,292,380	0.252114
4.	Anesthesiology	688,988	4,689,138	0.146933
5.	Radiology - Diagnostic	9,619,542	36,007,040	0.267157
6.	Radiology - Therapeutic	804,199	5,856,183	0.137325
7.	Nuclear Medicine	985,257	5,717,498	0.172323
8.	Laboratory	9,966,712	52,819,085	0.188695
9.	Diabetes Treatment Center			
10.	Doctors Office Center			
11.	Mercy Rheumatology Center			
12.	Respiratory Therapy	1,951,176	9,573,520	0.203810
13.	Physical Therapy	1,205,226	3,541,568	0.340309
14.	Occupational Therapy	1,249,704	2,879,601	0.433985
15.	Speech Pathology	266,782	545,607	0.488964
16.	Peds Practice			
17.	EEG	110,385	298,054	0.370352
18.	Med. / Surg. Supplies	2,727,240	3,500,723	0.779050
19.	Drugs Charged to Patients	12,163,759	34,441,766	0.353169
20.	Renal Dialysis	581,124	2,816,048	0.206362
21.	Ambulance			
22.	G.I. Lab	883,944	3,347,470	0.264063
23.	MRI Center	1,158,424	5,668,082	0.204377
23.01	Pulmonary Rehab			
23.02	ASC (Non-distinct Part)	1,603,044	302,364	5.301703
23.03	Urology Services			
23.04	Industrial Nursing			
23.05	Audiology	129,328	63,290	2.043419
23.06	Electrodiagnosis [EMG]	91,343	649,623	0.140609
23.07	Cardiovascular Labs	10,025,196	44,152,137	0.227060
23.08	Mercy Eye Center	596,778	875,611	0.681556
23.09	Wound Management	411,319	1,305,202	0.315138
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	7,987,759	11,936,768	0.669173
25.	Emergency	8,289,971	28,725,617	0.288592
26.	Observation Beds (Non-distinct Part)	1,831,233	1,817,407	1.007608
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	31,302,294	36,733	852.16
28.	Psychiatric Unit	3,626,791	6,608	548.85
29.	Rehabilitation Unit	2,664,182	4,791	556.08
30.				
31.	Intensive Care Unit	4,901,094	3,396	1,443.20
32.	Coronary Care Unit	2,051,568	1,716	1,195.55
33.	Nursery ICU/Special Care Nursery	1,658,735	2,565	646.68
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	393,248	3,529	111.43

