

# Hospital Statement of Cost

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

**General Information**

**PRELIMINARY**

Name of Hospital: St. Mary's Medical Center		Medicare Provider Number: 15-0100	
Street: 3700 Washington Avenue		Public Aid Provider Number: 5038	
City: Evansville	State: Indiana	Zip: 47750	
Period Covered by Statement:	From: 07/01/05	To: 06/30/06	

**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)) St. Mary's Medical Center 5038 for the cost report beginning 07/01/05 and ending 06/30/06 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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	297	108,405		47,658	43.96%		13,516	5.02	
2.	Stress Center	14	5,110		2,033	39.78%		313	6.50	
3.	Rehabilitation Unit	50	18,520		8,538	46.10%		668	12.78	
4.	Sub III									
5.	Intensive Care Unit	45	16,425		10,505	63.96%				
6.	Coronary Care Unit	9	3,285		1,416	43.11%				
7.	Neonatal ICU	32	11,680		8,281	70.90%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	42	15,330		2,994	19.53%				
16.	Total	489	178,755		81,425	45.55%		14,497	5.41	
17.	Observation Bed Days				9,234					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				502			153	6.46	
2.	Stress Center									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				180					
6.	Coronary Care Unit				57					
7.	Neonatal ICU				249					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				988	1.21%		153	6.46	

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:	15-0100	Public Aid Provider Number:	5038
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/05 To: 06/30/06

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	0.205849	163,599			33,677		
2.	Recovery Room	0.579342	13,315			7,714		
3.	Delivery and Labor Room	0.909705	112,178			102,049		
4.	Anesthesiology	0.093551	29,671			2,776		
5.	Radiology - Diagnostic	0.299035	88,156			26,362		
6.	Radiology - Therapeutic	0.323996	4,586			1,486		
7.	Nuclear Medicine	0.119828	21,746			2,606		
8.	Laboratory	0.201337	148,897			29,978		
9.	Blood							
10.	Blood - Administration	0.143487	26,363			3,783		
11.	Intravenous Therapy	0.293222	46,814			13,727		
12.	Respiratory Therapy	0.414083	205,516			85,101		
13.	Physical Therapy	0.496368	13,744			6,822		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.099025	28,306			2,803		
17.	EEG	0.240743	2,577			620		
18.	Med. / Surg. Supplies	0.450054	130,067			58,537		
19.	Drugs Charged to Patients	0.349257	298,329			104,193		
20.	Renal Dialysis	0.336272	2,803			943		
21.	Ambulance	0.732480						
22.	CAT Scan	0.091388	57,134			5,221		
23.	Diagnostic Ultrasound	0.262523	8,600			2,258		
23.01								
23.02	Cardiac Cath Lab	0.258154	218,045			56,289		
23.03	Cardiopulmonary	0.217135						
23.04	Electroconvulsive Therapy	2.961865						
23.05	Outreach Clinic	2.208398						
23.06	Senior Health / Family Practice	0.378328						
23.07	Bariatrics	4.824234						
23.08	Diagnostic Treatment Center	0.624535	11,791			7,364		
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.395347	55,897			22,099		
26.	Observation	0.879531						
27.	<b>Total</b>		1,688,134			576,408		

\* 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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

Line No.	Description	Adults and Pediatrics	Sub I Stress Center	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 522.22	\$ 804.18	\$ 512.59	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	502			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 262,154	\$	\$	\$
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 (BHF 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)	\$ 262,154	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 915.32	180	\$ 164,758
9.	Coronary Care Unit	\$ 1,214.99	57	\$ 69,254
10.	Neonatal ICU	\$ 757.00	249	\$ 188,493
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 210.49		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 576,408
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 1,261,067</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> 15-0100	<b>Public Aid Provider Number:</b> 5038
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07/01/05 To: 06/30/06

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 (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF 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.	Stress Center						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
9.	Other						
10.	Other						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
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										
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>15-0100</b>	Public Aid Provider Number: <b>5038</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>07/01/05</b> To: <b>06/30/06</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 (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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	970,803	56,465,570	0.017193	163,599			2,813		
2.	Recovery Room									
3.	Delivery and Labor Room	288,772	5,834,071	0.049498	112,178			5,553		
4.	Anesthesiology	3,509,085	3,140,733	1.117282	29,671			33,151		
5.	Radiology - Diagnostic	12,392	23,015,926	0.000538	88,156			47		
6.	Radiology - Therapeutic	162,750	8,239,439	0.019753	4,586			91		
7.	Nuclear Medicine	529,281	8,537,584	0.061994	21,746			1,348		
8.	Laboratory	300,386	42,254,865	0.007109	148,897			1,059		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	127,848	15,683,226	0.008152	28,306			231		
17.	EEG	253,562	3,520,646	0.072021	2,577			186		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance	7,453	3,414,981	0.002182						
22.	CAT Scan									
23.	Diagnostic Ultrasound									
23.01										
23.02	Cardiac Cath Lab	1,401	17,106,582	0.000082	218,045			18		
23.03	Cardiopulmonary									
23.04	Electroconvulsive Therapy	166,721	299,645	0.556395						
23.05	Outreach Clinic									
23.06	Senior Health / Family Practice	614,444	2,906,378	0.211412						
23.07	Bariatrics	2,594	148,169	0.017507						
23.08	Diagnostic Treatment Center									
23.09	Other									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	284,340	32,688,977	0.008698	55,897			486		
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	341,523	56,892	6.00	502			3,012		
28.	Stress Center									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU	10	8,281		249					
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	<b>Total</b>							47,995		

\* 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	1,261,067		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)	47,995		
5.	Services of Teaching Physicians (BHF 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>	1,309,062		
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)	1,688,134
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	189,455
	B. Stress Center	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	79,380
	F. Coronary Care Unit	25,830
	G. Neonatal ICU	268,513
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	2,251,312
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	942,250
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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	1,309,062		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,309,062		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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>	1,309,062		

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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

**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 (BHF Page 7, Line 12)	942,250
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 (BHF 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**

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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

**Part C. Program Cost**

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

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I Stress Center	Sub II Rehabilitation Ur	Sub III 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 BHF 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 BHF Page 4, Line 1)				

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

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

**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 BHF pgs. 3-4)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	11,623,401	56,465,570	0.205849
2.	Recovery Room	4,330,398	7,474,686	0.579342
3.	Delivery and Labor Room	5,307,284	5,834,071	0.909705
4.	Anesthesiology	293,819	3,140,733	0.093551
5.	Radiology - Diagnostic	6,882,566	23,015,926	0.299035
6.	Radiology - Therapeutic	2,669,542	8,239,439	0.323996
7.	Nuclear Medicine	1,023,038	8,537,584	0.119828
8.	Laboratory	8,507,461	42,254,865	0.201337
9.	Blood			
10.	Blood - Administration	680,523	4,742,743	0.143487
11.	Intravenous Therapy	1,843,121	6,285,752	0.293222
12.	Respiratory Therapy	4,051,494	9,784,257	0.414083
13.	Physical Therapy	5,820,945	11,727,087	0.496368
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	1,553,033	15,683,226	0.099025
17.	EEG	847,571	3,520,646	0.240743
18.	Med. / Surg. Supplies	45,277,627	100,604,966	0.450054
19.	Drugs Charged to Patients	18,856,884	53,991,423	0.349257
20.	Renal Dialysis	459,270	1,365,768	0.336272
21.	Ambulance	2,501,405	3,414,981	0.732480
22.	CAT Scan	2,233,545	24,440,315	0.091388
23.	Diagnostic Ultrasound	715,186	2,724,281	0.262523
23.01				
23.02	Cardiac Cath Lab	4,416,133	17,106,582	0.258154
23.03	Cardiopulmonary	716,125	3,298,068	0.217135
23.04	Electroconvulsive Therapy	887,508	299,645	2.961865
23.05	Outreach Clinic	780,651	353,492	2.208398
23.06	Senior Health / Family Practice	1,099,563	2,906,378	0.378328
23.07	Bariatrics	714,802	148,169	4.824234
23.08	Diagnostic Treatment Center	4,036,449	6,463,124	0.624535
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	12,923,492	32,688,977	0.395347
26.	Observation	4,451,065	5,060,725	0.879531
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	29,710,073	56,892	522.22
28.	Stress Center	1,634,893	2,033	804.18
29.	Rehabilitation Unit	4,376,481	8,538	512.59
30.	Sub III			
31.	Intensive Care Unit	9,615,486	10,505	915.32
32.	Coronary Care Unit	1,720,421	1,416	1,214.99
33.	Neonatal ICU	6,268,752	8,281	757.00
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	630,221	2,994	210.49

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

PRELIMINARY

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	975	13	988
Newborn Days			
Total Inpatient Revenue	2,228,955	22,357	2,251,312
Ancillary Revenue	1,665,924	22,210	1,688,134
Routine Revenue	563,031	147	563,178
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 2 charges match the Medicare W/S C charges.

Adjusted figures on BHF page 6, Column 1, to match W/S A-8-2.

Days and charges from the filed Rehab cost report were combined with the Acute days and charges.

This hospital is not approved for Illinois Medicaid Rehab.