

# 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: 07/01/2006	To: 06/30/2007	

**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 07/01/2006 and ending 06/30/2007; 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: 07/01/2006 To: 06/30/2007

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		47,734	44.03%		13,948	4.99	
2.	Stress Center	14	5,110		2,253	44.09%		398	5.66	
3.	Rehabilitation Unit	50	18,520		8,815	47.60%		650	13.56	
4.	Sub III									
5.	Intensive Care Unit	45	16,425		10,917	66.47%				
6.	Coronary Care Unit	9	3,285		1,299	39.54%				
7.	Neonatal ICU	32	11,680		9,697	83.02%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	42	15,330		2,853	18.61%				
16.	Total	489	178,755		83,568	46.75%		14,996	5.38	
17.	Observation Bed Days				7,682					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				844			229	5.78	
2.	Stress Center									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				165					
6.	Coronary Care Unit				5					
7.	Neonatal ICU				309					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				1,323	1.58%		229	5.78	

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: 07/01/2006 To: 06/30/2007

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	0.586400	134,755			79,020		
2.	Recovery Room	0.472165	9,882			4,666		
3.	Delivery and Labor Room	0.950882	210,552			200,210		
4.	Anesthesiology	0.044336	10,063			446		
5.	Radiology - Diagnostic	0.409392	56,579			23,163		
6.	Radiology - Therapeutic	0.362674						
7.	Nuclear Medicine	0.225626	15,350			3,463		
8.	Laboratory	0.292594	199,027			58,234		
9.	Blood							
10.	Blood - Administration	0.653250	77,357			50,533		
11.	Intravenous Therapy	0.297534						
12.	Respiratory Therapy	0.414644	281,246			116,617		
13.	Physical Therapy	0.453698	124,723			56,587		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG/Card. Cath/CardPul/ECT	0.264868	322,558			85,435		
17.	EEG	0.424580	2,253			957		
18.	Med. / Surg. Supplies	0.305330	153,899			46,990		
19.	Drugs Charged to Patients	0.398724	466,297			185,924		
20.	Renal Dialysis	0.706906	2,939			2,078		
21.	Ambulance	0.775120						
22.	CAT Scan	0.124591	73,855			9,202		
23.	Diagnostic Ultrasound	0.347647	14,895			5,178		
23.01								
23.02								
23.03								
23.04								
23.05	Outreach Clinic							
23.06	Senior Health / Family Practice	1.274479						
23.07	Bariatrics							
23.08	Diagnostic Treatment Center	0.544127	16,836			9,161		
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.366837	61,177			22,442		
26.	Observation	0.746269						
27.	<b>Total</b>		2,234,243			960,306		

\* 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: 07/01/2006 To: 06/30/2007

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)	\$ 498.68	\$ 761.69	\$ 511.92	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	844			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 420,886	\$	\$	\$
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)	\$ 420,886	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 896.00	165	\$ 147,840
9.	Coronary Care Unit	\$ 1,246.21	5	\$ 6,231
10.	Neonatal ICU	\$ 661.03	309	\$ 204,258
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 201.90		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 960,306
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 1,739,521</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: 07/01/2006 To: 06/30/2007

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>07/01/2006</b> To: <b>06/30/2007</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	995,637	56,095,562	0.017749	134,755			2,392		
2.	Recovery Room									
3.	Delivery and Labor Room	266,900	5,455,383	0.048924	210,552			10,301		
4.	Anesthesiology	3,507,241	4,003,300	0.876087	10,063			8,816		
5.	Radiology - Diagnostic	11,942	23,700,342	0.000504	56,579			29		
6.	Radiology - Therapeutic	35,250	8,012,606	0.004399						
7.	Nuclear Medicine	198,540	10,478,752	0.018947	15,350			291		
8.	Laboratory	345,215	35,091,677	0.009838	199,027			1,958		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG/Card. Cath/CardPul/ECT	185,775	37,047,109	0.005015	322,558			1,618		
17.	EEG	136,119	2,706,133	0.050300	2,253			113		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients	2,675	59,474,464	0.000045	466,297			21		
20.	Renal Dialysis									
21.	Ambulance									
22.	CAT Scan									
23.	Diagnostic Ultrasound									
23.01										
23.02										
23.03										
23.04										
23.05	Outreach Clinic									
23.06	Senior Health / Family Practice	307,196	1,260,481	0.243713						
23.07	Bariatrics									
23.08	Diagnostic Treatment Center									
23.09	Other									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	521,735	33,604,273	0.015526	61,177			950		
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	58,717	55,416	1.06	844			895		
28.	Stress Center									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU									
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>							27,384		

\* 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: 07/01/2006 To: 06/30/2007

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)	1,739,521		
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)	27,384		
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>	1,766,905		
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)	2,234,243
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	350,116
	B. Stress Center	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	104,908
	F. Coronary Care Unit	17,969
	G. Neonatal ICU	316,840
	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>	3,024,076
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,257,171
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: 07/01/2006 To: 06/30/2007

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)	1,766,905		
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)	1,766,905		
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>	1,766,905		

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: 07/01/2006 To: 06/30/2007

**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)	1,257,171
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 (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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	<b>Total (Sum of Lines 1 - 3)</b>							

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

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

**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 Unit	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 Unit	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 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 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**

<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: 07/01/2006 To: 06/30/2007

**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	32,894,429	56,095,562	0.586400
2.	Recovery Room	4,363,218	9,240,871	0.472165
3.	Delivery and Labor Room	5,187,425	5,455,383	0.950882
4.	Anesthesiology	177,490	4,003,300	0.044336
5.	Radiology - Diagnostic	9,702,742	23,700,342	0.409392
6.	Radiology - Therapeutic	2,905,967	8,012,606	0.362674
7.	Nuclear Medicine	2,364,276	10,478,752	0.225626
8.	Laboratory	10,267,627	35,091,677	0.292594
9.	Blood			
10.	Blood - Administration	3,159,917	4,837,222	0.653250
11.	Intravenous Therapy	2,117,037	7,115,269	0.297534
12.	Respiratory Therapy	4,259,836	10,273,482	0.414644
13.	Physical Therapy	5,785,541	12,751,962	0.453698
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG/Card. Cath/CardPul/ECT	9,812,581	37,047,109	0.264868
17.	EEG	1,148,969	2,706,133	0.424580
18.	Med. / Surg. Supplies	34,294,345	112,318,785	0.305330
19.	Drugs Charged to Patients	23,713,907	59,474,464	0.398724
20.	Renal Dialysis	2,185,936	3,092,259	0.706906
21.	Ambulance	2,535,193	3,270,711	0.775120
22.	CAT Scan	3,466,559	27,823,419	0.124591
23.	Diagnostic Ultrasound	966,970	2,781,472	0.347647
23.01				
23.02				
23.03				
23.04				
23.05	Outreach Clinic	766,651		
23.06	Senior Health / Family Practice	1,606,456	1,260,481	1.274479
23.07	Bariatrics			
23.08	Diagnostic Treatment Center	3,988,073	7,329,305	0.544127
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	12,327,290	33,604,273	0.366837
26.	Observation	3,823,946	5,124,082	0.746269
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	27,634,864	55,416	498.68
28.	Stress Center	1,716,088	2,253	761.69
29.	Rehabilitation Unit	4,512,600	8,815	511.92
30.	Sub III			
31.	Intensive Care Unit	9,781,621	10,917	896.00
32.	Coronary Care Unit	1,618,827	1,299	1,246.21
33.	Neonatal ICU	6,410,050	9,697	661.03
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	576,026	2,853	201.90

**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: 07/01/2006 To: 06/30/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,323		1,323
Newborn Days			
Total Inpatient Revenue	3,024,076		3,024,076
Ancillary Revenue	2,234,243		2,234,243
Routine Revenue	789,833		789,833
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, Column 4.

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.

Included Total Nursery Days & Observation Bed Days from W/S S-3.

Figures for EKG also include Cardiac Cath Lab, Cardiopulmonary, and ECT as hospital has grouped them on filed Medicaid report.

Took split between Adults & Peds and the ICU, Coronary ICU and NICU from provider workpapers for days & charges.

Per phone call from Stacey Tenbarga @ St. Mary's, she agrees with split in workpapers. DW 03/20/2008