

# Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

**General Information** Revised PRELIMINARY

Name of Hospital: St. Margaret Mercy Healthcare- North		Medicare Provider Number: 15-0004
Street: 5454 Hohman Avenue		Medicaid Provider Number: 8017
City: Hammond	State: Indiana	Zip: 46320
Period Covered by Statement:	From: 01-01-07	To: 12-31-07

**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. Margaret Mercy Healthcar 8017 for the cost report beginning 01-01-07 and ending 12-31-07 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 Healthcare and Family Services 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

Revised PRELIMINARY

Medicare Provider Number:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-07 To: 12-31-07

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	219	79,935		48,720	60.95%		11,977	4.80	
2.	Psychiatric Unit	58	21,170		9,431	44.55%		1,793	5.26	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	20	7,300		4,792	65.64%				
6.	Coronary Care Unit									
7.	Neonatal ICU	16	5,840		4,023	68.89%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,025					
16.	Total	313	114,245		68,991	60.39%		13,770	4.86	
17.	Observation Bed Days				2,665					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				2,154					
2.	Psychiatric Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				1,850					
6.	Coronary Care Unit									
7.	Neonatal ICU									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				746					
16.	Total				4,750	6.88%				

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

Revised PRELIMINARY

Medicare Provider Number:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-07 To: 12-31-07

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/Open Heart/OP S	0.674154	546,286			368,281		
2.	Recovery Room	0.247991	354,354			87,877		
3.	Delivery and Labor Room							
4.	Anesthesiology	1.339615	81,074			108,608		
5.	Radiology - Diagnostic/Special Pro.	0.218675	1,396,481			305,375		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.188176	205,109			38,597		
8.	Laboratory	0.167937	2,344,114			393,663		
9.	Blood							
10.	Blood - Administration	0.330045	168,438			55,592		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.270551	1,048,408			283,648		
13.	Physical Therapy	0.449690	99,584			44,782		
14.	Occupational Therapy	0.310111	27,407			8,499		
15.	Speech Pathology	0.745513	36,398			27,135		
16.	EKG	0.124015	634,833			78,729		
17.	EEG	0.325769	21,837			7,114		
18.	Med. / Surg. Supplies	0.254584	2,172,741			553,145		
19.	Drugs Charged to Patients	0.231341	3,858,180			892,555		
20.	Renal Dialysis							
21.	Ambulance							
22.	Open Heart Surgery							
23.	Outpatient Surgery							
23.01	Radiology Special Procedure							
23.02	Ultrasound							
23.03	CT Scan	0.083614	227,952			19,060		
23.04	Orthopedic Clinic							
23.05	Cardiovascular							
23.06	Radiation Oncology							
23.07	MRI							
23.08	Psych Activity Therapy							
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.278088	136,261			37,893		
25.	Emergency	0.334836	48,624			16,281		
26.	Observation	0.914337	52,197			47,726		
27.	<b>Total</b>		13,460,278			3,374,560		

\* 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

Revised PRELIMINARY

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 703.53	\$ 614.34	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,154			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,515,404	\$	\$	\$
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)	\$ 1,515,404	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,430.87	1,850	\$ 2,647,110
9.	Coronary Care Unit	\$		\$
10.	Neonatal ICU	\$ 910.24		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$	746	\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 3,374,560
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 7,537,074</b>

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

<b>Medicare Provider Number:</b> 15-0004	<b>Medicaid Provider Number:</b> 8017
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-07 To: 12-31-07

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.	Psychiatric Unit						
4.	Sub II						
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

Revised PRELIMINARY

Medicare Provider Number:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-07 To: 12-31-07

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/Open Heart/OP Sur									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	3,912,909	2,430,111	1.610177	81,074			130,543		
5.	Radiology - Diagnostic/Special Pro./U									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Open Heart Surgery									
23.	Outpatient Surgery									
23.01	Radiology Special Procedure									
23.02	Ultrasound									
23.03	CT Scan									
23.04	Orthopedic Clinic									
23.05	Cardiovascular									
23.06	Radiation Oncology									
23.07	MRI									
23.08	Psych Activity Therapy									
23.09	Other									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic	76,612	33,583,699	0.002281	136,261			311		
25.	Emergency	3,553,913	25,070,877	0.141755	48,624			6,893		
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	1,814,231	51,385	35.31	2,154			76,058		
28.	Psychiatric Unit									
29.	Sub II									
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>							213,805		

\* 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**

Revised PRELIMINARY

Medicare Provider Number: 15-0004		Medicaid Provider Number: 8017		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-07 To: 12-31-07		
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)	7,537,074		
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)	213,805		
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>	7,750,879		
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)	13,460,278
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	3,902,768
	B. Psychiatric Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal ICU	
	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>	17,363,046
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	9,612,167
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**

Revised PRELIMINARY

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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)	7,750,879		
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)	7,750,879		
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>	7,750,879		

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**

Revised PRELIMINARY

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

**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)	9,612,167
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

Revised PRELIMINARY

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

**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 Sub II	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 Psychiatric Unit	Sub II Sub II	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 Psychiatric Unit	Sub II Sub II	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

Revised PRELIMINARY

<b>Medicare Provider Number:</b> 15-0004	<b>Medicaid Provider Number:</b> 8017
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-07 To: 12-31-07

**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/Open Heart/OP Surgery	9,668,411	14,341,557	0.674154
2.	Recovery Room	818,681	3,301,250	0.247991
3.	Delivery and Labor Room			
4.	Anesthesiology	3,255,414	2,430,111	1.339615
5.	Radiology - Diagnostic/Special Pro./Ultrasound	6,025,919	27,556,453	0.218675
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	1,269,536	6,746,540	0.188176
8.	Laboratory	8,003,736	47,659,158	0.167937
9.	Blood			
10.	Blood - Administration	1,672,743	5,068,230	0.330045
11.	Intravenous Therapy			
12.	Respiratory Therapy	3,458,770	12,784,170	0.270551
13.	Physical Therapy	2,413,105	5,366,150	0.449690
14.	Occupational Therapy	765,236	2,467,623	0.310111
15.	Speech Pathology	591,614	793,566	0.745513
16.	EKG	1,050,967	8,474,507	0.124015
17.	EEG	674,950	2,071,865	0.325769
18.	Med. / Surg. Supplies	12,939,268	50,825,139	0.254584
19.	Drugs Charged to Patients	12,670,739	54,770,877	0.231341
20.	Renal Dialysis			
21.	Ambulance			
22.	Open Heart Surgery			
23.	Outpatient Surgery			
23.01	Radiology Special Procedure			
23.02	Ultrasound			
23.03	CT Scan	2,491,522	29,797,980	0.083614
23.04	Orthopedic Clinic			
23.05	Cardiovascular			
23.06	Radiation Oncology			
23.07	MRI			
23.08	Psych Activity Therapy			
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	9,339,208	33,583,699	0.278088
25.	Emergency	8,394,626	25,070,877	0.334836
26.	Observation	1,874,561	2,050,186	0.914337
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	36,151,067	51,385	703.53
28.	Psychiatric Unit	5,793,874	9,431	614.34
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	6,856,750	4,792	1,430.87
32.	Coronary Care Unit			
33.	Neonatal ICU	3,661,897	4,023	910.24
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery		2,025	

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

Revised PRELIMINARY

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,806	198	4,004
Newborn Days	553	193	746
Total Inpatient Revenue	12,500,237	4,862,809	17,363,046
Ancillary Revenue	12,267,491	1,192,787	13,460,278
Routine Revenue	232,746	3,670,022	3,902,768
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 BHF Supplement No. 2 charges match the filed W/S C charges.
- Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.
- Reclassified Radiology-Therapeutic charges on BHF page 3 with Computed Tomography (CT) for which there is a cost to charge ratio.
- Preparer of this Medicaid Report has grouped Lines 59--59.08 together in Clinic. The centers should've been properly broken out same as Medicare.
- Cardiac Rehab has been removed as this area is non-covered for Illinois Medicaid.
- Revised Room & Board charges came from Nancy Riley, Regional Reimbursement Manager on 08/01/2008.
- Revised Days & Ancillary charges came from Nancy Riley, Regional Reimbursement Manager on 08/20/2008.