

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: Lutheran General Hospital		Medicare Provider Number: 14-0223	
Street: 1775 West Dempster Street		Public Aid Provider Number: 16017	
City: Park Ridge	State: Illinois	Zip: 60068	
Period Covered by Statement:	From: 01-01-02	To: 12-31-02	

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)) Lutheran General Hospital 16017 for the cost report beginning 01-01-02 and ending 12-31-02 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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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	345	125,627		89,231	71.03%		25,181	3.92	
2.	Psychiatric Unit	53	19,216		13,294	69.18%		1,551	8.57	
3.	Rehabilitation Unit	37	13,353		12,286	92.01%		839	14.64	
4.										
5.	Intensive Care Unit	24	8,760		6,813	77.77%				
6.	Coronary Care Unit	10	3,650		2,600	71.23%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	43	15,695		7,895	50.30%				
16.	Total	512	186,301		132,119	70.92%		27,571	4.51	
17.	Observation Bed Days				4,446					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				4,927			1,317	4.29	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				593					
6.	Coronary Care Unit				136					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,054					
16.	Total				6,710	5.08%		1,317	4.29	

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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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	0.463445	1,742,990			807,780		
2.	Recovery Room	0.247556	119,851			29,670		
3.	Delivery and Labor Room	0.523185	1,898,561			993,299		
4.	Anesthesiology	0.126819	729,057			92,458		
5.	Radiology - Diagnostic	0.245261	1,618,553			396,968		
6.	Radiology - Therapeutic	0.347207	22,650			7,864		
7.	Radioisotope	0.284670	329,930			93,921		
8.	Laboratory	0.294851	1,861,617			548,900		
9.	Anti-Coag Lab	0.747616						
10.	Blood - Administration	0.255523	439,975			112,424		
11.	Heart Risk Assessment	0.785597						
12.	Respiratory Therapy	0.186464	995,187			185,567		
13.	Physical Therapy	0.575603	184,070			105,951		
14.	Occupational Therapy	0.786395	2,607			2,050		
15.	Speech Pathology							
16.	EKG	0.129522	337,134			43,666		
17.	EEG	0.310495	78,247			24,295		
18.	Med. / Surg. Supplies	0.114570	108,697			12,453		
19.	Drugs Charged to Patients	0.176582	1,206,856			213,109		
20.	Renal Dialysis	0.492095	4,660,773			2,293,543		
21.	Ambulance	1.117012						
22.	ASC (Non-distinct Part)	0.398187						
23.	Rehab Medicine	0.859215	8,775			7,540		
23.01	Cardiac Lab	0.285293	353,366			100,813		
23.02	Day Hospital	0.951920						
23.03	Lithotripter	0.258124	17,310			4,468		
23.04	Colo-rectal Center	0.245847						
23.05	Gastroenterology Lab	0.190389	117,218			22,317		
23.06	Diabetes Care Center	6.631667						
23.07	Pain Clinic	0.646086	230			149		
23.08	Cardiac Conditioning	0.739291						
23.09	Wound Care Center	1.158450	13,616			15,773		
Outpatient Service Cost Centers								
24.	Outpatient Center	0.721578	999			721		
25.	Emergency	0.391773						
26.	Observation Beds (Non-distinct Part)	0.676581						
27.	Total		16,848,269			6,115,699		

* 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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)	\$ 776.97	\$ 853.84	\$ 544.48	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	4,927			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 3,828,131	\$	\$	\$
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)	\$ 3,828,131	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,549.67	593	\$ 918,954
9.	Coronary Care Unit	\$ 1,823.52	136	\$ 247,999
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 273.37	1,054	\$ 288,132
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 6,115,699
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 11,398,915

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

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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.							
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.	Outpatient Center										
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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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.	Radioisotope									
8.	Laboratory									
9.	Anti-Coag Lab									
10.	Blood - Administration									
11.	Heart Risk Assessment									
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.	ASC (Non-distinct Part)									
23.	Rehab Medicine									
23.01	Cardiac Lab									
23.02	Day Hospital									
23.03	Lithotripter									
23.04	Colo-rectal Center									
23.05	Gastroenterology Lab									
23.06	Diabetes Care Center									
23.07	Pain Clinic									
23.08	Cardiac Conditioning									
23.09	Wound Care Center									
Outpatient Ancillary Cost Centers										
24.	Outpatient Center									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total									

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

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

PRELIMINARY

Medicare Provider Number: 14-0223		Public Aid Provider Number: 16017		
Program: Medicaid-Hospital [Acute]		Period Covered by Statement: From: 01-01-02 To: 12-31-02		
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)	11,398,915		
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.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	11,398,915		
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)	16,848,269
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	4,920,967
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	1,162,952
	F. Coronary Care Unit	267,117
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	400,520
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	23,599,825
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	12,200,910
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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)	11,398,915		
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)	11,398,915		
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.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	11,398,915		

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.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)			

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(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)	12,200,910
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 (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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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)
Inpatient Ancillary Centers				
1.	Operating Room	49,062,450	105,864,684	0.463445
2.	Recovery Room	2,326,611	9,398,330	0.247556
3.	Delivery and Labor Room	7,657,341	14,636,016	0.523185
4.	Anesthesiology	2,581,533	20,356,009	0.126819
5.	Radiology - Diagnostic	22,018,843	89,777,195	0.245261
6.	Radiology - Therapeutic	5,047,291	14,536,834	0.347207
7.	Radioisotope	5,206,672	18,290,182	0.284670
8.	Laboratory	20,658,201	70,063,144	0.294851
9.	Anti-Coag Lab	1,104,805	1,477,770	0.747616
10.	Blood - Administration	2,928,875	11,462,284	0.255523
11.	Heart Risk Assessment	629,491	801,290	0.785597
12.	Respiratory Therapy	6,276,832	33,662,459	0.186464
13.	Physical Therapy	6,027,013	10,470,776	0.575603
14.	Occupational Therapy	7,627,355	9,699,143	0.786395
15.	Speech Pathology			
16.	EKG	2,981,917	23,022,439	0.129522
17.	EEG	1,847,212	5,949,246	0.310495
18.	Med. / Surg. Supplies	3,395,672	29,638,387	0.114570
19.	Drugs Charged to Patients	20,517,482	116,192,696	0.176582
20.	Renal Dialysis	1,182,479	2,402,949	0.492095
21.	Ambulance	1,248,351	1,117,581	1.117012
22.	ASC (Non-distinct Part)	4,595,057	11,539,951	0.398187
23.	Rehab Medicine	1,143,453	1,330,812	0.859215
23.01	Cardiac Lab	8,335,086	29,215,882	0.285293
23.02	Day Hospital	3,650,097	3,834,459	0.951920
23.03	Lithotripter	964,420	3,736,263	0.258124
23.04	Colo-rectal Center	290,064	1,179,858	0.245847
23.05	Gastroenterology Lab	4,139,924	21,744,505	0.190389
23.06	Diabetes Care Center	441,616	66,592	6.631667
23.07	Pain Clinic	835,129	1,292,597	0.646086
23.08	Cardiac Conditioning	621,152	840,200	0.739291
23.09	Wound Care Center	231,851	200,139	1.158450
Outpatient Ancillary Centers				
24.	Outpatient Center	487,137	675,100	0.721578
25.	Emergency	12,950,066	33,054,992	0.391773
26.	Observation Beds (Non-distinct Part)	2,865,180	4,234,795	0.676581
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	72,784,034	93,677	776.97
28.	Psychiatric Unit	11,350,955	13,294	853.84
29.	Rehabilitation Unit	6,689,488	12,286	544.48
30.				
31.	Intensive Care Unit	10,557,930	6,813	1,549.67
32.	Coronary Care Unit	4,741,157	2,600	1,823.52
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,158,242	7,895	273.37

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

PRELIMINARY

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 01-01-02 To: 12-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,656		5,656
Newborn Days	1,054		1,054
Total Inpatient Revenue	23,599,825		23,599,825
Ancillary Revenue	16,848,269		16,848,269
Routine Revenue	6,751,556		6,751,556
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

Filed OHF Supplement No. 2 charges match the filed W/S C charges.

Reclassified "Blood" charges as Blood Administration. Blood is noncovered for Illinois Medicaid.