

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: St. Mary's Health Center		Medicare Provider Number: 26-0091	
Street: 6420 Clayton Road		Public Aid Provider Number: 19035	
City: St. Louis	State: Missouri	Zip: 63117	
Period Covered by Statement:	From: 01-01-02	To: 12-31-02	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation	<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 Health Center 19035 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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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	354	131,295	14,241	70,514	53.71%		16,062	4.63	
2.	Psychiatric Unit	38	13,870	79	8,796	63.42%		1,172	7.51	
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit	12	4,380		3,813	87.05%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	49	17,791		12,135	68.21%				
16.	Total	453	167,336	14,320	95,258	56.93%		17,234	4.82	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,755			283	6.28	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit				21					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,893					
16.	Total				3,669	3.85%		283	6.28	

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:	26-0091	Public Aid Provider Number:	19035
Program:	Medicaid-Hospital	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	0.416281	267,492			111,352		
2.	Recovery Room	0.241797	20,428			4,939		
3.	Delivery and Labor Room	0.353056	1,198,712			423,212		
4.	Anesthesiology	0.198208	110,571			21,916		
5.	Radiology - Diagnostic	0.165609	207,181			34,311		
6.	Radiology - Therapeutic	0.270125						
7.	Nuclear Medicine	0.200188	17,776			3,559		
8.	Laboratory	0.169095	714,408			120,803		
9.								
10.	Blood - Administration	0.475390	116,142			55,213		
11.	Intravenous Therapy	0.274573	44,897			12,328		
12.	Respiratory Therapy	0.091743	1,748,149			160,380		
13.	Physical Therapy	0.632910	6,590			4,171		
14.	Occupational Therapy	0.509381	200			102		
15.	Speech Pathology	0.606128	1,769			1,072		
16.	EKG	0.094387	22,105			2,086		
17.	EEG	0.698040	1,074			750		
18.	Med. / Surg. Supplies	0.473435	4,995			2,365		
19.	Drugs Charged to Patients	0.376378	280,323			105,507		
20.	Renal Dialysis							
21.	Transport Services							
22.	Diagnostic Ultrasound	0.183914	31,571			5,806		
23.	Anatomic Pathology	0.132482	49,385			6,543		
23.01	Mental Hygiene	0.367772						
23.02	Pharmacy IV-Drug Therapy	0.216785	679,840			147,379		
23.03	Sleep Disorder	0.312024						
23.04	Pain Management	0.205800						
23.05	Psychotherapy	0.341384						
23.06	Cardiac Catheterization	0.214658	179,962			38,630		
23.07	Vascular Lab	0.092815	64,810			6,015		
23.08	Endoscopy	0.212172	11,151			2,366		
23.09	Hemodialysis	0.207330	44,540			9,234		
Outpatient Service Cost Centers								
24.	Clinic	0.963402	6,578			6,337		
25.	Emergency	0.228332						
26.	Observation Beds (Non-distinct Par							
27.	Total		5,830,649			1,286,376		

* 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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 642.52	\$ 435.70	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,755			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,127,623	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 91.86	\$ 22.03	\$	\$
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)	\$ 1,127,623	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$ 1,239.98	21	\$ 26,040
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 568.68	1,893	\$ 1,076,511
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,286,376
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 3,516,550

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

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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.							
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.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number:	26-0091	Public Aid Provider Number:	19035
Program:	Medicaid-Hospital	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	39,400	58,464,844	0.000674	267,492			180		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	19,910	13,415,980	0.001484	110,571			164		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	373,455	9,281,141	0.040238	17,776			715		
8.	Laboratory	136,775	48,670,862	0.002810	714,408			2,007		
9.										
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	2,917	28,046,066	0.000104	1,748,149			182		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	237,330	5,592,704	0.042436	22,105			938		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Transport Services									
22.	Diagnostic Ultrasound									
23.	Anatomic Pathology	82,447	4,738,905	0.017398	49,385			859		
23.01	Mental Hygiene									
23.02	Pharmacy IV-Drug Therapy									
23.03	Sleep Disorder	2,917	440,787	0.006618						
23.04	Pain Management									
23.05	Psychotherapy									
23.06	Cardiac Catheterization	5,000	27,082,240	0.000185	179,962			33		
23.07	Vascular Lab									
23.08	Endoscopy	38,811	12,478,973	0.003110	11,151			35		
23.09	Hemodialysis									
Outpatient Ancillary Cost Centers										
24.	Clinic	35,756	1,202,774	0.029728	6,578			196		
25.	Emergency	2,665,227	29,623,120	0.089971						
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	47,555	70,514	0.67	1,755			1,176		
28.	Psychiatric Unit									
29.										
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							6,485		

* 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: 26-0091		Public Aid Provider Number: 19035		
Program: Medicaid-Hospital		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)	3,516,550		
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)	6,485		
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)	3,523,035		
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)	5,830,649
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,610,560
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	44,872
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	2,861,211
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	10,347,292
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	6,824,257
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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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)	3,523,035		
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)	3,523,035		
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)	3,523,035		

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: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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)	6,824,257
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

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

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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	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	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	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)	76,707,738	7,278,658		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	59,497,924	7,210,011		
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	17,209,814	68,647		
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	56,273	8,717		
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	14,241	79		
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	1,208.47	868.95		
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	1,057.31	827.12		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	151.16	41.83		
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))	91.86	22.03		
7. Private room cost differential adjustment (Line 2B X Line 6)	1,308,178	1,740		
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)	45,306,776	3,832,386		
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)	642.52	435.70		

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	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	24,337,825	58,464,844	0.416281
2.	Recovery Room	1,389,153	5,745,125	0.241797
3.	Delivery and Labor Room	5,749,732	16,285,608	0.353056
4.	Anesthesiology	2,659,154	13,415,980	0.198208
5.	Radiology - Diagnostic	7,795,721	47,073,167	0.165609
6.	Radiology - Therapeutic	1,420,678	5,259,337	0.270125
7.	Nuclear Medicine	1,857,969	9,281,141	0.200188
8.	Laboratory	8,229,989	48,670,862	0.169095
9.				
10.	Blood - Administration	3,479,215	7,318,656	0.475390
11.	Intravenous Therapy	895,826	3,262,615	0.274573
12.	Respiratory Therapy	2,573,030	28,046,066	0.091743
13.	Physical Therapy	1,120,830	1,770,914	0.632910
14.	Occupational Therapy	85,680	168,204	0.509381
15.	Speech Pathology	136,780	225,662	0.606128
16.	EKG	527,878	5,592,704	0.094387
17.	EEG	150,034	214,936	0.698040
18.	Med. / Surg. Supplies	256,246	541,248	0.473435
19.	Drugs Charged to Patients	5,340,662	14,189,637	0.376378
20.	Renal Dialysis			
21.	Transport Services			
22.	Diagnostic Ultrasound	592,413	3,221,136	0.183914
23.	Anatomic Pathology	627,821	4,738,905	0.132482
23.01	Mental Hygiene	236,532	643,148	0.367772
23.02	Pharmacy IV-Drug Therapy	8,855,953	40,851,228	0.216785
23.03	Sleep Disorder	137,536	440,787	0.312024
23.04	Pain Management	614,324	2,985,047	0.205800
23.05	Psychotherapy	1,481,561	4,339,866	0.341384
23.06	Cardiac Catheterization	5,813,411	27,082,240	0.214658
23.07	Vascular Lab	665,645	7,171,739	0.092815
23.08	Endoscopy	2,647,684	12,478,973	0.212172
23.09	Hemodialysis	804,441	3,879,997	0.207330
Outpatient Ancillary Centers				
24.	Clinic	1,158,755	1,202,774	0.963402
25.	Emergency	6,763,918	29,623,120	0.228332
26.	Observation Beds (Non-distinct Part)		6,048,249	
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics			See Supplement 1
28.	Psychiatric Unit			See Supplement 1
29.				
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit	4,728,048	3,813	1,239.98
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	6,900,874	12,135	568.68

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

PRELIMINARY

Medicare Provider Number: 26-0091	Public Aid Provider Number: 19035
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,776		1,776
Newborn Days	1,893		1,893
Total Inpatient Revenue	10,347,376	(84)	10,347,292
Ancillary Revenue	5,830,733	(84)	5,830,649
Routine Revenue	4,516,643		4,516,643
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:

- Subtracted Children's A&P & Adolescent Psych data from W/S S-3 A&P data to determine A&P data for this report.
- Determined that CCU Bed Days Available = 4,380 as per the filed OHF-2. The number of CCU Beds = 12 for FYE 12-99, 12-00, 12-01 and 12-02.
- Inspected the filed cost-to-charge ratios.
- Determined Blood Administration charges to be Anatomic Pathology.
- Determined Blood charges to be Blood Administration.
- Determined Renal Dialysis charges to be Hemodialysis.
- Removed \$84 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.
- Filed OHF Supplement No. 2 charges for Nuclear Medicine, Laboratory, EKG, Cardiac Catheterization, Clinic and ER are greater than the W/S C charges.