

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: Grant Hospital		Medicare Provider Number: 14-0207	
Street: 550 West Webster		Public Aid Provider Number: 3031	
City: Chicago	State: Illinois	Zip: 60614	
Period Covered by Statement:	From: 08-31-02	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 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)) Grant Hospital 3031 for the cost report beginning 08-31-02 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: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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	96	11,808	550	5,755	48.74%		1,383	4.80	
2.	Rehabilitation Unit	20	2,460	203	1,055	42.89%		75	14.07	
3.	Psychiatric Unit	30	3,690	4	2,614	70.84%		353	7.41	
4.										
5.	Intensive Care Unit	12	1,476		877	59.42%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	40	4,920		573	11.65%				
16.	Total	198	24,354	757	10,874	44.65%		1,811	5.69	
17.	Observation Bed Days				151					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			143	1,417			361	4.55	
2.	Rehabilitation Unit									
3.	Psychiatric Unit									
4.										
5.	Intensive Care Unit				225					
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				359					
16.	Total			143	2,001	18.40%		361	4.55	

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:	14-0207	Public Aid Provider Number:	3031
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 08-31-02 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	0.751999	85,117			64,008		
2.	Recovery Room	0.411026	73,568			30,238		
3.	Delivery and Labor Room	1.047550	345,887			362,334		
4.	Anesthesiology	0.106634	125,502			13,383		
5.	Radiology - Diagnostic	0.717741	103,441			74,244		
6.	Radiology - Therapeutic							
7.	Radioisotope	0.347752	35,405			12,312		
8.	Laboratory	0.196984	808,629			159,287		
9.	Blood							
10.	Blood - Administration	0.442122	61,038			26,986		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.169204	277,407			46,938		
13.	Physical Therapy	0.476463	11,439			5,450		
14.	Occupational Therapy	0.400773	2,838			1,137		
15.	Speech Pathology	0.737562	17,607			12,986		
16.	EKG/ Cardiac Cath Lab	0.089007	331,482			29,504		
17.	EEG	1.292709	1,569			2,028		
18.	Med. / Surg. Supplies	0.134204	730,782			98,074		
19.	Drugs Charged to Patients	0.204590	1,345,315			275,238		
20.	Renal Dialysis	0.961784	23,737			22,830		
21.	Ambulance							
22.	Ultrasound	0.345203						
23.	Magnetic Resonance Imaging	0.115829	7,742			897		
23.01	CT Scan	0.171248	65,153			11,157		
23.02	Minor Procedures	1.582011						
23.03	Endoscopy/ Gastrointestinal	0.341974	18,787			6,425		
23.04	Partial Hospitalization Program	0.238601						
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic	1.231832						
25.	Emergency	0.671083	7,801			5,235		
26.	Observation Beds (Non-distinct Par	0.675637	59,919			40,483		
27.	Total		4,540,165			1,301,174		

* 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: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 To: 12-31-02

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Psychiatric Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 484.62	\$ 487.16	\$ 530.26	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,417			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 686,707	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 137.93	\$ 51.36	\$ 127.47	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)	143			
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$ 19,724	\$	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$ 706,431	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,175.46	225	\$ 264,479
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 990.98	359	\$ 355,762
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,301,174
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,627,846

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

Medicare Provider Number: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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.	Rehabilitation Unit						
4.	Psychiatric 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.	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:	14-0207	Public Aid Provider Number:	3031
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 08-31-02 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.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG/ Cardiac Cath Lab									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Magnetic Resonance Imaging									
23.01	CT Scan									
23.02	Minor Procedures									
23.03	Endoscopy/ Gastrointestinal									
23.04	Partial Hospitalization Program									
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Psychiatric 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: 14-0207		Public Aid Provider Number: 3031		
Program: Medicaid-Hospital		Period Covered by Statement: From: 08-31-02 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)	2,627,846		
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)	2,627,846		
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)	4,540,165
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,892,684
	B. Rehabilitation Unit	
	C. Psychiatric Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	6,432,849
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	3,805,003
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: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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)	2,627,846		
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)	2,627,846		
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)	2,627,846		

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: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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)	3,805,003
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: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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 Rehabilitation Ur	Sub II Psychiatric Unit	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 Rehabilitation Ur	Sub II Psychiatric Unit	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 Rehabilitation Ur	Sub II Psychiatric 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)	4,988,350	928,956	2,228,329	
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	4,407,000	735,294	2,224,101	
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	581,350	193,662	4,228	
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	5,356	852	2,610	
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	550	203	4	
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	1,057.00	954.00	1,057.00	
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	822.82	863.02	852.15	
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	234.18	90.98	204.85	
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))	137.93	51.36	127.47	
7. Private room cost differential adjustment (Line 2B X Line 6)	75,862	10,426	510	
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)	2,862,157	513,954	1,386,096	
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)	484.62	487.16	530.26	

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 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	1,072,468	1,426,157	0.751999
2.	Recovery Room	110,813	269,601	0.411026
3.	Delivery and Labor Room	868,106	828,701	1.047550
4.	Anesthesiology	55,255	518,174	0.106634
5.	Radiology - Diagnostic	593,928	827,496	0.717741
6.	Radiology - Therapeutic			
7.	Radioisotope	106,811	307,147	0.347752
8.	Laboratory	822,080	4,173,336	0.196984
9.	Blood			
10.	Blood - Administration	132,981	300,779	0.442122
11.	Intravenous Therapy			
12.	Respiratory Therapy	361,617	2,137,172	0.169204
13.	Physical Therapy	271,136	569,060	0.476463
14.	Occupational Therapy	162,513	405,499	0.400773
15.	Speech Pathology	38,514	52,218	0.737562
16.	EKG/ Cardiac Cath Lab	188,383	2,116,508	0.089007
17.	EEG	16,897	13,071	1.292709
18.	Med. / Surg. Supplies	813,602	6,062,434	0.134204
19.	Drugs Charged to Patients	1,186,611	5,799,942	0.204590
20.	Renal Dialysis	87,406	90,879	0.961784
21.	Ambulance			
22.	Ultrasound	146,761	425,144	0.345203
23.	Magnetic Resonance Imaging	21,222	183,218	0.115829
23.01	CT Scan	133,719	780,851	0.171248
23.02	Minor Procedures	139,728	88,323	1.582011
23.03	Endoscopy/ Gastrointestinal	76,329	223,201	0.341974
23.04	Partial Hospitalization Program	195,254	818,327	0.238601
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic	73,055	59,306	1.231832
25.	Emergency	576,476	859,023	0.671083
26.	Observation Beds (Non-distinct Part)	75,116	111,178	0.675637
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics			See Supplement 1
28.	Rehabilitation Unit			See Supplement 1
29.	Psychiatric Unit			See Supplement 1
30.				
31.	Intensive Care Unit	1,030,878	877	1,175.46
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	567,834	573	990.98

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

PRELIMINARY

Medicare Provider Number: 14-0207	Public Aid Provider Number: 3031
Program: Medicaid-Hospital	Period Covered by Statement: From: 08-31-02 To: 12-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,642		1,642
Newborn Days	359		359
Total Inpatient Revenue	6,432,849		6,432,849
Ancillary Revenue	4,540,165		4,540,165
Routine Revenue	1,892,684		1,892,684
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:

No W/S C, Part I was filed.

Accepted W/S C charges from the filed OHF Supplement No. 2.

Filed Medicaid data were taken from the Inpatient Paid Claims Summary for charges paid through 05-02-03.