

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: Northwestern Memorial Hospital		Medicare Provider Number: 14-0281	
Street: 251 E. Huron		Public Aid Provider Number: 3122	
City: Chicago	State: Illinois	Zip: 60611	
Period Covered by Statement:	From: 09-01-01	To: 08-31-02	

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 XXXX XXXX	<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 XXXX XXXX	<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 XXXX XXXX	<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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09-01-01 and ending 08-31-02 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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occu-pancy (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	495	179,301		154,218	86.01%		39,381	4.81	
2.	Psychiatric Unit	55	20,075		16,898	84.17%		1,561	10.83	
3.										
4.										
5.	Intensive Care Unit	67	24,455		19,266	78.78%				
6.	Coronary Care Unit									
7.	Special Care Nursery	46	16,790		15,879	94.57%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	48	17,520		18,790	107.25%				
16.	Total	711	258,141		225,051	87.18%		40,942	5.04	
17.	Observation Bed Days				1,576					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				21,587			4,753	6.17	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				2,458					
6.	Coronary Care Unit									
7.	Special Care Nursery				5,292					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				2,232					
16.	Total				31,569	14.03%		4,753	6.17	

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:	14-0281	Public Aid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09-01-01 To: 08-31-02

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	0.449991	6,210,001			2,794,445		
2.	Recovery Room	0.673009	267,409			179,969		
3.	Delivery and Labor Room	0.415859	5,750,342			2,391,331		
4.	Anesthesiology	0.373346	383,847			143,308		
5.	Radiology - Diagnostic	0.345108	7,443,375			2,568,768		
6.	Radiology - Therapeutic	0.364310	494,352			180,097		
7.	Radioisotope	0.372321	385,502			143,530		
8.	Laboratory	0.289722	9,468,140			2,743,128		
9.	Outside Health Services	1.917038						
10.	Blood - Administration	0.556946	2,360,407			1,314,619		
11.	Kidney Acquisition [per W/S D-6]	0.314607	260,604			81,988		
12.	Respiratory Therapy	0.214432	6,556,127			1,405,843		
13.	Physical Therapy	0.446008	733,994			327,367		
14.	Occupational Therapy	0.456306	244,894			111,747		
15.	Liver Acquisition [per W/S D-6]	0.338446	501,162			169,616		
16.	EKG	0.251081	445,281			111,802		
17.	EEG	0.394530	247,485			97,640		
18.	Med. / Surg. Supplies	0.150099	9,509,485			1,427,364		
19.	Drugs Charged to Patients	0.314660	14,472,316			4,553,859		
20.	Renal Dialysis	0.566405	616,638			349,267		
21.	Pancreas Acquisition [per W/S D-6]	0.312943						
22.	Catheterization Lab	0.481541	1,723,981			830,168		
23.	Cardiology Graphics	0.375441	546,747			205,271		
23.01	Pulmonary Function Testing	0.319771	57,210			18,294		
23.02	Dental Services	1.251307	12,777			15,988		
23.03	Magnetic Resonance Imaging	0.270136	1,119,454			302,405		
23.04	Blood Flow Lab	0.299547	304,735			91,282		
23.05	Cellrifuge	0.727993	93,961			68,403		
23.06	Urodynamics	0.698337						
23.07	Cast Room	0.537905	3,017			1,623		
23.08	OB Clinic Services	1.697167	104,484			177,327		
23.09	GI Laboratory	0.529841	280,152			148,436		
Outpatient Service Cost Centers								
24.	Clinic	1.658519	9,592			15,909		
25.	Emergency	0.829387	904,633			750,291		
26.	Solid Organ Transplant	1.612928	289			466		
27.	Total		71,512,393			23,721,551		

* 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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)	\$ 830.00	\$ 728.73	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	21,587			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 17,917,210	\$	\$	\$
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)	\$ 17,917,210	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,662.15	2,458	\$ 4,085,565
9.	Coronary Care Unit	\$		\$
10.	Special Care Nursery	\$ 965.62	5,292	\$ 5,110,061
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 130.58	2,232	\$ 291,455
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 23,721,551
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 51,125,842

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

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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.	Special Care Nursery						
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.	Solid Organ Transplant										
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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.	Outside Health Services									
10.	Blood - Administration									
11.	Kidney Acquisition [per W/S D-6]									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Liver Acquisition [per W/S D-6]									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Pancreas Acquisition [per W/S D-6]									
22.	Catheterization Lab									
23.	Cardiology Graphics									
23.01	Pulmonary Function Testing									
23.02	Dental Services									
23.03	Magnetic Resonance Imaging									
23.04	Blood Flow Lab									
23.05	Celltrifuge									
23.06	Urodynamics									
23.07	Cast Room									
23.08	OB Clinic Services									
23.09	GI Laboratory									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Solid Organ Transplant									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Special Care Nursery									
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			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)	51,125,842		
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)	51,125,842		
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)	71,512,393
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	22,459,089
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	5,533,884
	F. Coronary Care Unit	
	G. Special Care Nursery	10,321,293
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	1,371,782
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	111,198,441
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	60,072,599
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)	51,125,842		
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)	51,125,842		
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)	51,125,842		

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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)	60,072,599
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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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)				
(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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

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	78,009,842	173,358,840	0.449991
2.	Recovery Room	10,305,609	15,312,730	0.673009
3.	Delivery and Labor Room	15,626,281	37,575,908	0.415859
4.	Anesthesiology	4,523,929	12,117,254	0.373346
5.	Radiology - Diagnostic	55,585,204	161,066,230	0.345108
6.	Radiology - Therapeutic	10,499,425	28,820,025	0.364310
7.	Radioisotope	8,118,315	21,804,621	0.372321
8.	Laboratory	38,710,249	133,611,821	0.289722
9.	Outside Health Services	5,626,757	2,935,130	1.917038
10.	Blood - Administration	13,697,299	24,593,573	0.556946
11.	Kidney Acquisition [per W/S D-6]	714,349	2,270,608	0.314607
12.	Respiratory Therapy	9,163,355	42,733,088	0.214432
13.	Physical Therapy	3,448,230	7,731,315	0.446008
14.	Occupational Therapy	1,304,626	2,859,104	0.456306
15.	Liver Acquisition [per W/S D-6]	201,981	596,790	0.338446
16.	EKG	3,034,206	12,084,553	0.251081
17.	EEG	3,174,989	8,047,513	0.394530
18.	Med. / Surg. Supplies	13,796,769	91,918,021	0.150099
19.	Drugs Charged to Patients	43,617,083	138,616,466	0.314660
20.	Renal Dialysis	3,096,108	5,466,244	0.566405
21.	Pancreas Acquisition [per W/S D-6]	1,279	4,087	0.312943
22.	Catheterization Lab	19,537,712	40,573,326	0.481541
23.	Cardiology Graphics	4,423,943	11,783,317	0.375441
23.01	Pulmonary Function Testing	982,170	3,071,479	0.319771
23.02	Dental Services	2,456,231	1,962,932	1.251307
23.03	Magnetic Resonance Imaging	12,932,333	47,873,396	0.270136
23.04	Blood Flow Lab	1,782,629	5,951,088	0.299547
23.05	Cellitrifuge	1,247,941	1,714,220	0.727993
23.06	Urodynamics	591,972	847,688	0.698337
23.07	Cast Room	81,797	152,066	0.537905
23.08	OB Clinic Services	10,180,318	5,998,417	1.697167
23.09	GI Laboratory	9,119,637	17,212,021	0.529841
Outpatient Ancillary Centers				
24.	Clinic	10,138,713	6,113,111	1.658519
25.	Emergency	16,854,146	20,321,208	0.829387
26.	Solid Organ Transplant	1,923,513	1,192,560	1.612928
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	129,308,973	155,794	830.00
28.	Psychiatric Unit	12,314,127	16,898	728.73
29.				
30.				
31.	Intensive Care Unit	32,022,954	19,266	1,662.15
32.	Coronary Care Unit			
33.	Special Care Nursery	15,333,051	15,879	965.62
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	2,453,623	18,790	130.58

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

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09-01-01 To: 08-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	29,337		29,337
Newborn Days	2,232		2,232
Total Inpatient Revenue	111,206,598	(8,157)	111,198,441
Ancillary Revenue	71,520,550	(8,157)	71,512,393
Routine Revenue	39,686,048		39,686,048
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 adjustment was made to the filed W/S C charges to prepare the filed OHF reports.

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

Removed \$8,157 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.

See 02-06-03 fax from Fred S. Sese for breakdown of "Other" charges.