

# 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: Barnes-Jewish Hospital		Medicare Provider Number: 26-0032	
Street: One Barnes-Jewish Hospital Plaza		Public Aid Provider Number: 19014	
City: St. Louis	State: Missouri	Zip: 63110	
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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) XXXX XXXX	<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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Psychiatric Unit	<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)) Barnes-Jewish Hospital 19014 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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	1,063	367,129	41,199	217,600	59.27%		47,723	5.22	
2.	Psychiatric Unit	87	31,755	5,421	19,549	61.56%		1,780	10.98	
3.										
4.										
5.	Intensive Care Unit	29	10,616		8,277	77.97%				
6.	Coronary Care Unit	15	5,475		4,460	81.46%				
7.	Surgical ICU	24	8,586		6,068	70.67%				
8.	ENT ICU	4	1,460		1,087	74.45%				
9.	Neuro ICU	20	7,300		4,901	67.14%				
10.	Cardiothoracic ICU	25	9,125		6,923	75.87%				
11.										
12.										
13.										
14.										
15.	Newborn Nursery	35	12,775		11,899	93.14%				
16.	Total	1,302	454,221	46,620	280,764	61.81%		49,503	5.43	
17.	Observation Bed Days				582					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit			17	75			8	9.38	
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU									
8.	ENT ICU									
9.	Neuro ICU									
10.	Cardiothoracic ICU									
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total			17	75	0.03%		8	9.38	

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:	26-0032	Public Aid Provider Number:	19014
Program:	Medicaid-Psychiatric	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	0.471556						
2.	Recovery Room	0.403940						
3.	Delivery and Labor Room	0.367103						
4.	Anesthesiology	0.339088						
5.	Radiology - Diagnostic	0.334450	641			214		
6.	Radiology - Therapeutic	0.285993						
7.	Radioisotope	0.296388						
8.	Laboratory	0.175450	7,671			1,346		
9.	Blood							
10.	Blood - Administration	0.255828	439			112		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.185512	168			31		
13.	Physical Therapy	0.506115						
14.	Occupational Therapy	0.345912						
15.	Speech Pathology	0.499907						
16.	EKG	0.112779	1,885			213		
17.	EEG	0.319106						
18.	Med. / Surg. Supplies	0.313055	113			35		
19.	Drugs Charged to Patients	0.326493	12,575			4,106		
20.	Renal Dialysis	0.309613						
21.	Ambulance	1.152170						
22.	HLA Lab	0.285211						
23.	CT Scan	0.091122	827			75		
23.01	Ultrasound	0.194179						
23.02	Cardiac Catheterization Laboratory	0.328412						
23.03	Endoscopy	0.335706						
23.04	OB/ Gyn In Vitro	0.776992						
23.05	Outpatient Pharmacy	1.914907						
23.06	Electroshock Therapy	0.541815						
23.07	O/P Psych Services	0.833255						
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	1.803329						
25.	Emergency	0.610919	4,430			2,706		
26.	Observation Beds (Non-distinct Par	6.087299						
27.	<b>Total</b>		28,749			8,838		

\* 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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)	\$ 759.58	\$ 663.53	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		75		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 49,765	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 182.85	\$ 243.17	\$	\$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)		17		
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	\$	\$ 4,134	\$	\$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	\$	\$ 53,899	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,956.49		\$
9.	Coronary Care Unit	\$ 1,114.44		\$
10.	Surgical ICU	\$ 1,532.55		\$
11.	ENT ICU	\$ 1,265.91		\$
12.	Neuro ICU	\$ 1,296.79		\$
13.	Cardiothoracic ICU	\$ 1,241.63		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 449.06		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 8,838
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 62,737

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

<b>Medicare Provider Number:</b> 26-0032	<b>Public Aid Provider Number:</b> 19014
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> 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.	Surgical ICU						
9.	ENT ICU						
10.	Neuro ICU						
10.01	Cardiothoracic ICU						
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: <b>26-0032</b>	Public Aid Provider Number: <b>19014</b>
Program: <b>Medicaid-Psychiatric</b>	Period Covered by Statement: From: <b>01-01-02</b> To: <b>12-31-02</b>

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	70,800	245,264,074	0.000289						
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	2,132,000	34,010,401	0.062687						
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic	320,004	48,591,819	0.006586						
7.	Radioisotope									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration	106,798	87,272,550	0.001224	439			1		
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	HLA Lab									
23.	CT Scan									
23.01	Ultrasound									
23.02	Cardiac Catheterization Laboratory	2,814	93,811,216	0.000030						
23.03	Endoscopy									
23.04	OB/ Gyn In Vitro									
23.05	Outpatient Pharmacy									
23.06	Electroshock Therapy									
23.07	O/P Psych Services									
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	440,060	50,546,500	0.008706	4,430			39		
26.	Observation Beds (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	401,299	218,182	1.84						
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Surgical ICU									
34.	ENT ICU									
35.	Neuro ICU									
35.01	Cardiothoracic ICU									
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							40		

\* 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**

<b>Medicare Provider Number:</b> 26-0032		<b>Public Aid Provider Number:</b> 19014		
<b>Program:</b> Medicaid-Psychiatric		<b>Period Covered by Statement:</b> 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)	62,737		
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)	40		
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	62,777		
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)	28,749
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	50,640
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Surgical ICU	
	H. ENT ICU	
	I. Neuro ICU	
	J. Cardiothoracic ICU	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	79,389
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	16,612
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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)	62,777		
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)	62,777		
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	62,777		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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**

<b>Line No.</b>	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (OHF Page 7, Line 12)	16,612
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.	<b>Total (Sum of Lines 1 - 3)</b>							

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

OHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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)	123,930,213	11,170,520		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	96,157,663	7,328,150		
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	27,772,550	3,842,370		
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	176,983	14,128		
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	41,199	5,421		
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	674.11	708.79		
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	543.32	518.70		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	130.79	190.09		
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))	182.85	243.17		
7. Private room cost differential adjustment (Line 2B X Line 6)	7,533,237	1,318,225		
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)	165,726,578	12,971,441		
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)	759.58	663.53		

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	115,655,761	245,264,074	0.471556
2.	Recovery Room	11,560,450	28,619,236	0.403940
3.	Delivery and Labor Room	8,264,193	22,511,937	0.367103
4.	Anesthesiology	11,532,511	34,010,401	0.339088
5.	Radiology - Diagnostic	48,298,248	144,411,131	0.334450
6.	Radiology - Therapeutic	13,896,903	48,591,819	0.285993
7.	Radioisotope	5,146,311	17,363,405	0.296388
8.	Laboratory	44,401,981	253,075,531	0.175450
9.	Blood			
10.	Blood - Administration	22,326,740	87,272,550	0.255828
11.	Intravenous Therapy			
12.	Respiratory Therapy	10,358,084	55,835,138	0.185512
13.	Physical Therapy	5,031,831	9,942,073	0.506115
14.	Occupational Therapy	1,346,226	3,891,820	0.345912
15.	Speech Pathology	695,625	1,391,508	0.499907
16.	EKG	5,788,704	51,327,934	0.112779
17.	EEG	1,257,465	3,940,589	0.319106
18.	Med. / Surg. Supplies	17,778,614	56,790,792	0.313055
19.	Drugs Charged to Patients	84,756,626	259,596,821	0.326493
20.	Renal Dialysis	2,462,990	7,955,054	0.309613
21.	Ambulance	1,766,315	1,533,033	1.152170
22.	HLA Lab	1,451,434	5,088,984	0.285211
23.	CT Scan	6,637,805	72,845,175	0.091122
23.01	Ultrasound	2,532,079	13,039,945	0.194179
23.02	Cardiac Catheterization Laboratory	30,808,717	93,811,216	0.328412
23.03	Endoscopy	7,190,689	21,419,582	0.335706
23.04	OB/ Gyn In Vitro	1,788,016	2,301,203	0.776992
23.05	Outpatient Pharmacy	1,488,794	777,476	1.914907
23.06	Electroshock Therapy	557,089	1,028,190	0.541815
23.07	O/P Psych Services	2,453,100	2,943,997	0.833255
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	21,365,721	11,847,931	1.803329
25.	Emergency	30,879,827	50,546,500	0.610919
26.	Observation Beds (Non-distinct Part)	359,455	59,050	6.087299
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics			See Supplement 1
28.	Psychiatric Unit			See Supplement 1
29.				
30.				
31.	Intensive Care Unit	16,193,888	8,277	1,956.49
32.	Coronary Care Unit	4,970,421	4,460	1,114.44
33.	Surgical ICU	9,299,529	6,068	1,532.55
34.	ENT ICU	1,376,048	1,087	1,265.91
35.	Neuro ICU	6,355,578	4,901	1,296.79
35.01	Cardiothoracic ICU	8,595,814	6,923	1,241.63
35.02				
35.03				
35.04				
35.05				
36.	Nursery	5,343,322	11,899	449.06

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

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01-01-02 To: 12-31-02

<b>Inpatient Reconciliation</b>	<b>Provider's Records</b>	<b>Adjustments</b>	<b>Audited Cost Report</b>
Adult Days	75		75
Newborn Days			
Total Inpatient Revenue	79,389		79,389
Ancillary Revenue	28,749		28,749
Routine Revenue	50,640		50,640
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Determined that no change was made to the filed W/S C charges to prepare the filed OHF report..

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