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: Saint Anthony's Health Center	Medicare Provider Number: 14-0052
Street: 1 Saint Anthony's Way, P.O. Box 340	Public Aid Provider Number: 1003
City: Alton / State: Illinois	Zip: 62002-0340
Period Covered by Statement: From: 01-01-03	To: 12-31-03

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
XXXX XXXX	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

XXXX XXXX	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
	Medicaid Sub I		Medicaid Sub III		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)) Saint Anthony's Health Cente 1003 for the cost report beginning 01-01-03 and ending 12-31-03 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Signed (Officer or Administrator of Provider(s)):

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.

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Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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	88	32,120	7,441	20,590	64.10%		6,021	3.72	
2.	Comprehensive Rehab Unit	15	5,475		2,889	52.77%		284	10.17	
3.	Psychiatric Unit	18	6,570	983	4,476	68.13%		1,902	2.35	
4.										
5.	Intensive Care Unit	10	3,650		1,807	49.51%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	8	2,920		1,742	59.66%				
16.	Total	139	50,735	8,424	31,504	62.10%		8,207	3.63	
17.	Observation Bed Days				216					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			405	2,335			908	2.75	
2.	Comprehensive Rehab Unit									
3.	Psychiatric Unit									
4.										
5.	Intensive Care Unit				158					
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				622					
16.	**Total**			405	3,115	9.89%		908	2.75	

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: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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 Total Billed O/P Charges (Gross) for Health Care Program Patients	Referred O/P E/R Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	Referred O/P E/R O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.276988	730,103			202,230		
2.	Recovery Room	0.130566	148,351			19,370		
3.	Delivery and Labor Room	0.494750	1,024,643			506,942		
4.	Anesthesiology	0.068733	122,521			8,421		
5.	Radiology - Diagnostic	0.109044	1,397,479			152,387		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.196547	1,561,172			306,844		
9.	Blood							
10.	Blood - Administration	0.457675	40,624			18,593		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.124490	598,848			74,551		
13.	Physical Therapy	0.294771	75,377			22,219		
14.	Occupational Therapy	0.373072	15,719			5,864		
15.	Speech Pathology	0.299232	15,396			4,607		
16.	EKG	0.096219	600,351			57,765		
17.	EEG	0.079526	9,858			784		
18.	Med. / Surg. Supplies	0.242825	945,651			229,628		
19.	Drugs Charged to Patients	0.187987	1,851,995			348,151		
20.	Renal Dialysis							
21.	Ambulance	0.972143						
22.	Oncology	0.532889						
23.	Diabetes Center	2.417612						
23.01	Psychiatric/ Psychological	0.546132	148			81		
23.02	Comprehensive Rehab Day Care	1.548994						
23.03	Good Samaritan Center	0.826837						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
	Outpatient Service Cost Centers							
24.	Clinic							
25.	Emergency	0.296285	424,327			125,722		
26.	Observation Beds (Non-distinct Par	1.027945	2,158			2,218		
27.	**Total**		9,564,721			2,086,377		

* 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.

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Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0052	1003
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01-01-03 To: 12-31-03

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

Line No.	Description	Adults and Pediatrics	Sub I Comprehensive Rehab	Sub II Psychiatric Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 434.29	$ 553.05	$ 434.29	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	2,335			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 1,014,067	$	$	$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	$ 58.76	$	$ 58.76	$
5.	Medically necessary private room days applicable to the program (OHF Page 2, Pt. II, Col. 3)	405			
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)	$ 23,798	$	$	$
7.	Total program inpatient routine service cost (Line 3 + Line 6)	$ 1,037,865	$	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,495.63	158	$ 236,310
9.	Coronary Care Unit	$		$
10.		$		$
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 186.70	622	$ 116,127
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 2,086,377
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **3,476,679**

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

PRELIMINARY

Medicare Provider Number: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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.	Comprehensive Rehab 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
		(1)	(2)	(3)	(4)	(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)**										

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

PRELIMINARY

Medicare Provider Number: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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	91,902	73,744,426	0.001246	1,397,479			1,741		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	14,196	15,651,283	0.000907	600,351			545		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Oncology									
23.	Diabetes Center									
23.01	Psychiatric/ Psychological									
23.02	Comprehensive Rehab Day Care	6,919	32,698	0.211603						
23.03	Good Samaritan Center	275,600	346,991	0.794257						
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	1,538,428	20,754,156	0.074126	424,327			31,454		
26.	Observation Beds (Non-distinct Part)									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	11,712	20,806	0.56	2,335			1,308		
28.	Comprehensive Rehab Unit	36,647	2,889	12.69						
29.	Psychiatric Unit	2,519	4,476	0.56						
30.										
31.	Intensive Care Unit	35,575	1,807	19.69	158			3,111		
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	**Total**							38,159		

* 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:	Public Aid Provider Number:
14-0052	1003
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01-01-03 To: 12-31-03

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	3,476,679		
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)	38,159		
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)**	3,514,838		
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)	9,564,721
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,221,804
	B. Comprehensive Rehab Unit	
	C. Psychiatric Unit	
	D.	
	E. Intensive Care Unit	214,248
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	228,146
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	11,228,919
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	7,714,081
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: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Line No.	Allowable Cost	Inpatient Hospital	Outpatient Organized Clinic	Outpatient Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	3,514,838		
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)	3,514,838		
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)**	3,514,838		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient Organized Clinic	Outpatient Referred Outpatient
		(1)	(2)	(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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)	7,714,081
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)	(4)	(5)
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)	(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 **OHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0052	**Public Aid Provider Number:** 1003
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 01-01-03 To: 12-31-03

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 Comprehensive**	**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 Comprehensive**	**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 Comprehensive**	**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)	10,012,300		2,115,583	
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	6,134,692		1,603,328	
	(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	3,877,608		512,255	
2.	Routine Days				
	(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	13,365		3,493	
	(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	7,441		983	
3.	Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	521.11		521.11	
4.	Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	459.01		459.01	
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	62.10		62.10	
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))**	58.76		58.76	
7.	Private room cost differential adjustment (Line 2B X Line 6)	437,233		57,761	
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)	9,035,768		1,943,869	
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)**	434.29		434.29	

Hospital Statement of Cost **OHF Supplement No. 2**

Graduate Medical Education Cost Adjustment Sheet

PRELIMINARY

Medicare Provider Number: 14-0052	Public Aid Provider Number: 1003
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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	6,832,288	24,666,380	0.276988
2.	Recovery Room	676,659	5,182,508	0.130566
3.	Delivery and Labor Room	2,603,380	5,262,010	0.494750
4.	Anesthesiology	225,049	3,274,234	0.068733
5.	Radiology - Diagnostic	8,041,378	73,744,426	0.109044
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	4,812,164	24,483,503	0.196547
9.	Blood			
10.	Blood - Administration	704,710	1,539,762	0.457675
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,319,009	10,595,338	0.124490
13.	Physical Therapy	2,388,316	8,102,276	0.294771
14.	Occupational Therapy	1,627,823	4,363,299	0.373072
15.	Speech Pathology	456,898	1,526,900	0.299232
16.	EKG	1,505,949	15,651,283	0.096219
17.	EEG	258,198	3,246,699	0.079526
18.	Med. / Surg. Supplies	3,513,388	14,468,782	0.242825
19.	Drugs Charged to Patients	4,751,972	25,278,218	0.187987
20.	Renal Dialysis			
21.	Ambulance	133,935	137,773	0.972143
22.	Oncology	169,790	318,622	0.532889
23.	Diabetes Center	259,168	107,200	2.417612
23.01	Psychiatric/ Psychological	197,644	361,898	0.546132
23.02	Comprehensive Rehab Day Care	50,649	32,698	1.548994
23.03	Good Samaritan Center	286,905	346,991	0.826837
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
	Outpatient Ancillary Centers			
24.	Clinic			
25.	Emergency	6,149,146	20,754,156	0.296285
26.	Observation Beds (Non-distinct Part)	98,069	95,403	1.027945
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics			See Supplement 1
28.	Comprehensive Rehab Unit	1,597,753	2,889	553.05
29.	Psychiatric Unit			See Supplement 1
30.				
31.	Intensive Care Unit	2,702,611	1,807	1,495.63
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	325,233	1,742	186.70

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0052	1003
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01-01-03 To: 12-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,493		2,493
Newborn Days	622		622
Total Inpatient Revenue	11,228,919		11,228,919
Ancillary Revenue	9,564,721		9,564,721
Routine Revenue	1,664,198		1,664,198
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:

Total A&P Beds = 106 - 18 Psych = 88; and Total A&P Bed Days Available = 38,690 - 6,570 Psych = 32,120.

Total discharges for the Psychiatric Unit = [7,923 per W/S S-3, Column 15] - [6021 per Acute, OHF-2, Line 1, Column 7] = 1,902.

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

Determined Other Outpatient Service/ Clinic to be Good Samaritan Center from the filed W/S A-8-2 description for Line 63.

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