

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: 01-01-03	To: 12-31-03	

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 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)) Barnes-Jewish Hospital 19014 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):

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-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 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	1,037	368,561	37,669	219,103	59.45%		47,530	5.29	
2.	Psychiatric Unit	67	25,075	4,815	18,139	72.34%		1,589	11.42	
3.										
4.										
5.	Intensive Care Unit	31	11,315		8,544	75.51%				
6.	Coronary Care Unit	15	5,475		4,345	79.36%				
7.	Surgical ICU	24	8,760		7,028	80.23%				
8.	ENT ICU	4	1,460		626	42.88%				
9.	Neuro ICU	20	7,300		5,140	70.41%				
10.	Cardiothoracic ICU	25	9,125		6,714	73.58%				
11.										
12.										
13.										
14.										
15.	Newborn Nursery	35	12,775		10,946	85.68%				
16.	Total	1,258	449,846	42,484	280,585	62.37%		49,119	5.49	
17.	Observation Bed Days				185					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				7,045			1,348	5.86	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				291					
6.	Coronary Care Unit				32					
7.	Surgical ICU				195					
8.	ENT ICU				20					
9.	Neuro ICU				180					
10.	Cardiothoracic ICU				130					
11.										
12.										
13.										
14.										
15.	Newborn Nursery				515					
16.	Total				8,408	3.00%		1,348	5.86	

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-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	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	0.477695	3,612,394			1,725,623		
2.	Recovery Room	0.471053	226,839			106,853		
3.	Delivery and Labor Room	0.412419	984,384			405,979		
4.	Anesthesiology	0.347667	506,757			176,183		
5.	Radiology - Diagnostic	0.304974	1,933,178			589,569		
6.	Radiology - Therapeutic	0.347468	230,428			80,066		
7.	Radioisotope	0.289681	123,269			35,709		
8.	Laboratory	0.162462	5,081,285			825,516		
9.	Blood							
10.	Blood - Administration	0.266591	2,540,444			677,260		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.197424	1,648,512			325,456		
13.	Physical Therapy	0.408217	189,849			77,500		
14.	Occupational Therapy	0.325212	82,403			26,798		
15.	Speech Pathology	0.446594	32,899			14,692		
16.	EKG	0.112672	621,443			70,019		
17.	EEG	0.235815	135,394			31,928		
18.	Med. / Surg. Supplies	0.309138	1,705,119			527,117		
19.	Drugs Charged to Patients	0.323956	7,419,978			2,403,746		
20.	Renal Dialysis	0.353234	97,751			34,529		
21.	Ambulance							
22.	HLA Lab	0.353587	6,075			2,148		
23.	CT Scan	0.085327	1,177,365			100,461		
23.01	Ultrasound	0.194005	126,086			24,461		
23.02	Cardiac Catheterization Laboratory	0.323799	1,541,239			499,052		
23.03	Endoscopy	0.355381	202,010			71,791		
23.04	Outpatient Pharmacy	0.701069						
23.05	Electroshock Therapy	0.457214						
23.06	O/P Psych Services	0.848542						
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic	1.834136	15,588			28,591		
25.	Emergency	0.523296	369,529			193,373		
26.	Observation Beds (Non-distinct Par	0.463857	1,331			617		
27.	Total		30,611,549			9,055,037		

* 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-Hospital	Period Covered by Statement: 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 Psychiatric Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 813.60	\$ 629.29	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	7,045			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 5,731,812	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$ 62.03	\$ 510.82	\$	\$
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)	\$ 5,731,812	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,036.54	291	\$ 592,633
9.	Coronary Care Unit	\$ 1,171.93	32	\$ 37,502
10.	Surgical ICU	\$ 1,533.46	195	\$ 299,025
11.	ENT ICU	\$ 1,461.68	20	\$ 29,234
12.	Neuro ICU	\$ 1,265.93	180	\$ 227,867
13.	Cardiothoracic ICU	\$ 1,267.46	130	\$ 164,770
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 498.07	515	\$ 256,506
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 9,055,037
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 16,394,386

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

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
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.	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: 26-0032	Public Aid Provider Number: 19014
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									
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									
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									
23.03	Endoscopy									
23.04	Outpatient Pharmacy									
23.05	Electroshock Therapy									
23.06	O/P Psych Services									
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.	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.	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: 26-0032		Public Aid Provider Number: 19014		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-03 To: 12-31-03		
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)	16,394,386		
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)	16,394,386		
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)	30,611,549
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	6,573,543
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	498,604
	F. Coronary Care Unit	54,149
	G. Surgical ICU	335,040
	H. ENT ICU	33,660
	I. Neuro ICU	318,901
	J. Cardiothoracic ICU	224,129
	K.	
	L.	
	M.	
	N.	
	O. Nursery	275,457
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	38,925,032
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	22,530,646
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-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)	16,394,386		
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)	16,394,386		
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)	16,394,386		

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
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)	22,530,646
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

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

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
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 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)	128,712,438	9,046,052		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)	105,224,467	5,466,779		
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)	23,487,971	3,579,273		
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)	181,619	13,324		
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)	37,669	4,815		
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)	623.54	743.36		
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)	579.37	410.30		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)	44.17	333.06		
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))	62.03	510.82		
7. Private room cost differential adjustment (Line 2B X Line 6)	2,336,608	2,459,598		
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)	178,411,646	11,414,602		
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)	813.60	629.29		

**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-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	122,824,477	257,118,919	0.477695
2.	Recovery Room	12,987,381	27,570,969	0.471053
3.	Delivery and Labor Room	8,886,962	21,548,388	0.412419
4.	Anesthesiology	12,307,535	35,400,310	0.347667
5.	Radiology - Diagnostic	49,331,573	161,756,391	0.304974
6.	Radiology - Therapeutic	17,481,677	50,311,560	0.347468
7.	Radioisotope	5,041,070	17,402,168	0.289681
8.	Laboratory	45,491,311	280,011,236	0.162462
9.	Blood			
10.	Blood - Administration	23,841,538	89,430,995	0.266591
11.	Intravenous Therapy			
12.	Respiratory Therapy	11,044,220	55,941,710	0.197424
13.	Physical Therapy	4,571,309	11,198,228	0.408217
14.	Occupational Therapy	1,302,410	4,004,799	0.325212
15.	Speech Pathology	558,020	1,249,502	0.446594
16.	EKG	6,375,874	56,587,692	0.112672
17.	EEG	997,062	4,228,156	0.235815
18.	Med. / Surg. Supplies	18,351,773	59,364,351	0.309138
19.	Drugs Charged to Patients	83,779,442	258,613,773	0.323956
20.	Renal Dialysis	2,721,732	7,705,187	0.353234
21.	Ambulance			
22.	HLA Lab	1,625,866	4,598,207	0.353587
23.	CT Scan	7,956,039	93,241,977	0.085327
23.01	Ultrasound	2,912,176	15,010,808	0.194005
23.02	Cardiac Catheterization Laboratory	32,265,620	99,647,092	0.323799
23.03	Endoscopy	8,566,042	24,103,816	0.355381
23.04	Outpatient Pharmacy	6,850,518	9,771,525	0.701069
23.05	Electroshock Therapy	532,885	1,165,505	0.457214
23.06	O/P Psych Services	2,724,152	3,210,391	0.848542
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic	24,394,308	13,300,164	1.834136
25.	Emergency	30,996,873	59,233,916	0.523296
26.	Observation Beds (Non-distinct Part)	115,024	247,973	0.463857
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics			See Supplement 1
28.	Psychiatric Unit			See Supplement 1
29.				
30.				
31.	Intensive Care Unit	17,400,199	8,544	2,036.54
32.	Coronary Care Unit	5,092,037	4,345	1,171.93
33.	Surgical ICU	10,777,142	7,028	1,533.46
34.	ENT ICU	915,012	626	1,461.68
35.	Neuro ICU	6,506,883	5,140	1,265.93
35.01	Cardiothoracic ICU	8,509,747	6,714	1,267.46
35.02				
35.03				
35.04				
35.05				
36.	Nursery	5,451,869	10,946	498.07

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

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,893		7,893
Newborn Days	515		515
Total Inpatient Revenue	38,925,032		38,925,032
Ancillary Revenue	30,611,549		30,611,549
Routine Revenue	8,313,483		8,313,483
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:

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

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

The private-room cost differential is calculated, as in prior FY, for this report. Dave W. approved this calculation, 07-02-04.