

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: University of Illinois Medical Center at Chicago		Medicare Provider Number: 14-0150
Street: 1740 W. Taylor Street		Public Aid Provider Number: 3098
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 07-01-02	To: 06-30-03

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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)) University of Illinois Medical C 3098 for the cost report beginning 07-01-02 and ending 06-30-03 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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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	285	104,025		70,095	67.38%		16,278	5.86	
2.	Psychiatric Unit	31	11,315		9,989	88.28%		576	17.34	
3.	Rehabilitation Unit	16	5,840		4,175	71.49%		376	11.10	
4.										
5.	Intensive Care Unit	21	7,665		6,430	83.89%				
6.	Coronary Care Unit	19	6,935		5,420	78.15%				
7.	Pediatric ICU	12	4,380		3,356	76.62%				
8.	Neonatal ICU	45	16,425		10,108	61.54%				
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	23	8,395		5,297	63.10%				
16.	Total	452	164,980		114,870	69.63%		17,230	6.36	
17.	Observation Bed Days				990					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				29,033			6,731	6.12	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit				1,144					
6.	Coronary Care Unit				1,856					
7.	Pediatric ICU				1,666					
8.	Neonatal ICU				7,482					
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				2,807					
16.	Total				43,988	38.29%		6,731	6.12	

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:	14-0150	Public Aid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-02 To: 06-30-03

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	0.464677	18,691,633			8,685,572		
2.	Neuropsych Clinic	1.420899	5,272			7,491		
3.	Delivery and Labor Room	0.631589	3,759,563			2,374,499		
4.	Anesthesiology	0.229291	5,013,591			1,149,571		
5.	Radiology - Diagnostic	0.803463	1,420,897			1,141,638		
6.	Kidney Acquisition [per W/S D-6]	0.920661	1,089,540			1,003,097		
7.	Nuclear Medicine-Diagnostic	0.584189	293,221			171,296		
8.	Laboratory	0.324530	18,908,820			6,136,479		
9.	Liver Transplant/Acquisition [W/S D	0.704474	911,778			642,324		
10.	Blood - Administration	0.410213	5,060,972			2,076,077		
11.								
12.	Respiratory Therapy	0.215000	6,421,759			1,380,678		
13.	Physical Therapy	0.767621	574,341			440,876		
14.	Occupational Therapy	0.951075	341,032			324,347		
15.	Speech Pathology	0.526786	270,129			142,300		
16.	EKG	0.232600	1,167,929			271,660		
17.	EEG							
18.	Med. / Surg. Supplies	0.632889	8,404,148			5,318,893		
19.	Drugs Charged to Patients	0.396786	34,558,962			13,712,512		
20.	Renal Dialysis	0.464286	1,162,374			539,674		
21.	Ambulance							
22.	Oncology	0.463103	1,298,192			601,197		
23.	CT Scan	0.205661	2,376,557			488,765		
23.01	Magnetic Resonance Imaging	0.210999	1,342,972			283,366		
23.02	Ultrasound	0.729026	590,539			430,518		
23.03	Vascular X-ray	0.257660	4,051,986			1,044,035		
23.04	Heart Cath Lab	0.317539	5,313,871			1,687,361		
23.05	Prosthetics	1.569000	3,437			5,393		
23.06	Other Organ Transplant	1.733629	111,727			193,693		
23.07	Eye Clinic	1.401750	3,819			5,353		
23.08	Primary Care Clinic	1.444930	66,234			95,703		
23.09	Child/Peds & Adolescent Center	0.880845	553,310			487,380		
Outpatient Service Cost Centers								
24.	Clinic	1.506138	85,953			129,457		
25.	Emergency	0.522591	2,740,494			1,432,157		
26.	Observation Beds (Non-distinct Par	0.636668						
27.	Total		126,595,052			52,403,362		

* 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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 773.25	\$ 718.90	\$ 629.77	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	29,033			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 22,449,767	\$	\$	\$
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)	\$ 22,449,767	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,620.94	1,144	\$ 1,854,355
9.	Coronary Care Unit	\$ 1,902.08	1,856	\$ 3,530,260
10.	Pediatric ICU	\$ 1,616.06	1,666	\$ 2,692,356
11.	Neonatal ICU	\$ 1,318.36	7,482	\$ 9,863,970
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 214.28	2,807	\$ 601,484
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 52,403,362
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 93,395,554

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

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Pediatric ICU						
9.	Neonatal ICU						
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

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

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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.	Neuropsych Clinic									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Kidney Acquisition [per W/S D-6]									
7.	Nuclear Medicine-Diagnostic									
8.	Laboratory									
9.	Liver Transplant/Acquisition [W/S D-4]									
10.	Blood - Administration									
11.										
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.	Oncology									
23.	CT Scan									
23.01	Magnetic Resonance Imaging									
23.02	Ultrasound									
23.03	Vascular X-ray									
23.04	Heart Cath Lab									
23.05	Prosthetics									
23.06	Other Organ Transplant									
23.07	Eye Clinic									
23.08	Primary Care Clinic									
23.09	Child/Peds & Adolescent Center									
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.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Pediatric ICU									
34.	Neonatal ICU									
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: 14-0150		Public Aid Provider Number: 3098		
Program: Medicaid-Hospital		Period Covered by Statement: From: 07-01-02 To: 06-30-03		
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)	93,395,554		
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)	93,395,554		
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)	126,595,052
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	28,626,542
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	1,964,300
	F. Coronary Care Unit	3,355,870
	G. Pediatric ICU	3,074,636
	H. Neonatal ICU	15,292,826
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	832,556
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	179,741,782
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	86,346,228
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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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)	93,395,554		
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)	93,395,554		
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)	93,395,554		

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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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)	86,346,228
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

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

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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 Rehabilitation Ur	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 Rehabilitation Ur	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 Rehabilitation Ur	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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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	43,580,524	93,786,666	0.464677
2.	Neuropsych Clinic	7,730,598	5,440,638	1.420899
3.	Delivery and Labor Room	8,140,537	12,888,974	0.631589
4.	Anesthesiology	4,743,217	20,686,471	0.229291
5.	Radiology - Diagnostic	5,974,480	7,435,908	0.803463
6.	Kidney Acquisition [per W/S D-6]	3,224,832	3,502,734	0.920661
7.	Nuclear Medicine-Diagnostic	1,705,187	2,918,897	0.584189
8.	Laboratory	28,166,018	86,790,216	0.324530
9.	Liver Transplant/Acquisition [W/S D-6]	1,687,019	2,394,723	0.704474
10.	Blood - Administration	7,194,020	17,537,293	0.410213
11.				
12.	Respiratory Therapy	4,077,656	18,965,837	0.215000
13.	Physical Therapy	3,077,870	4,009,621	0.767621
14.	Occupational Therapy	1,985,553	2,087,694	0.951075
15.	Speech Pathology	1,061,092	2,014,277	0.526786
16.	EKG	1,377,959	5,924,154	0.232600
17.	EEG			
18.	Med. / Surg. Supplies	15,885,301	25,099,653	0.632889
19.	Drugs Charged to Patients	45,545,358	114,785,794	0.396786
20.	Renal Dialysis	5,690,333	12,256,096	0.464286
21.	Ambulance			
22.	Oncology	8,822,862	19,051,611	0.463103
23.	CT Scan	2,582,558	12,557,372	0.205661
23.01	Magnetic Resonance Imaging	2,576,880	12,212,760	0.210999
23.02	Ultrasound	1,933,010	2,651,496	0.729026
23.03	Vascular X-ray	5,542,127	21,509,455	0.257660
23.04	Heart Cath Lab	8,373,370	26,369,545	0.317539
23.05	Prosthetics	1,224,879	780,675	1.569000
23.06	Other Organ Transplant	1,272,295	733,891	1.733629
23.07	Eye Clinic	5,859,530	4,180,153	1.401750
23.08	Primary Care Clinic	6,776,517	4,689,857	1.444930
23.09	Child/Peds & Adolescent Center	6,536,959	7,421,235	0.880845
Outpatient Ancillary Centers				
24.	Clinic	23,348,961	15,502,534	1.506138
25.	Emergency	11,004,908	21,058,360	0.522591
26.	Observation Beds (Non-distinct Part)	717,800	1,127,432	0.636668
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	54,966,384	71,085	773.25
28.	Psychiatric Unit	7,181,124	9,989	718.90
29.	Rehabilitation Unit	2,629,300	4,175	629.77
30.				
31.	Intensive Care Unit	10,422,650	6,430	1,620.94
32.	Coronary Care Unit	10,309,262	5,420	1,902.08
33.	Pediatric ICU	5,423,489	3,356	1,616.06
34.	Neonatal ICU	13,326,023	10,108	1,318.36
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,135,026	5,297	214.28

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

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	41,181		41,181
Newborn Days	2,807		2,807
Total Inpatient Revenue	179,741,782		179,741,782
Ancillary Revenue	126,595,052		126,595,052
Routine Revenue	53,146,730		53,146,730
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 All Patients" discharges and Medicaid discharges were taken from the filed W/S S-3.

Liver Transplant costs match Liver Acquisition costs per filed W/S B, Part I, Column 25. Redescribed the Liver Transplant cost center as Liver Transplant/Acquisition. Kidney Acquisition costs were also taken from the filed W/S B, Part I, Column 25.

Liver Transplant/Acquisition and Kidney Acquisition charges were taken from the filed OHF Supplement No. 2 instead of the filed W/S D-6, Line 51.

All other OHF Supplement No. 2 charges match the filed W/S C, Column 8 charges.

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