

# 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: Silver Cross Hospital		Medicare Provider Number: 14-0213	
Street: 1200 Maple Road		Public Aid Provider Number: 10004	
City: Joliet	State: Illinois	Zip: 60432	
Period Covered by Statement:	From: 10-01-02	To: 09-30-03	

**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 checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

**Type of Hospital**

<input checked="" type="checkbox"/> General Short-Term	<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 Mental Health Care 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)) Silver Cross Hospital 10004 for the cost report beginning 10-01-02 and ending 09-30-03 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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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	239	87,235		44,466	50.97%		13,158	3.67	
2.	Mental Health Care Unit	20	7,300		2,825	38.70%		718	3.93	
3.	Rehabilitation Unit	20	7,300		4,507	61.74%		395	11.41	
4.										
5.	Intensive Care Unit	18	6,570		3,823	58.19%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	26	9,490		3,967	41.80%				
16.	Total	323	117,895		59,588	50.54%		14,271	3.90	
17.	Observation Bed Days				3,173					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Mental Health Care Unit				776			211	3.68	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				776	1.30%		211	3.68	

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:	14-0213	Public Aid Provider Number:	10004
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 10-01-02 To: 09-30-03

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	0.297973	551			164		
2.	Recovery Room	0.241106	2,027			489		
3.	Delivery and Labor Room	1.112160						
4.	Anesthesiology	0.097440	542			53		
5.	Radiology - Diagnostic	0.237759	5,328			1,267		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.137245	60,796			8,344		
9.	Blood							
10.	Blood - Administration	0.326537	417			136		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.173503	535			93		
13.	Physical Therapy	0.549503	104			57		
14.	Occupational Therapy	0.464105	2			1		
15.	Speech Pathology	1.105737	40			44		
16.	EKG	0.232171	1,334			310		
17.	EEG	0.416879	320			133		
18.	Med. / Surg. Supplies	0.083108	3,010			250		
19.	Drugs Charged to Patients	0.318908	32,779			10,453		
20.	Renal Dialysis	0.297920	1,478			440		
21.	Ambulance							
22.	Ultrasound	0.197965	1,969			390		
23.	Outpatient Mental Health Unit	1.183558						
23.01	Diabetes Center	1.704724	86			147		
23.02								
23.03								
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	1.795501						
25.	Emergency	0.380557	25,382			9,659		
26.	Observation Beds (Non-distinct Par	0.776458						
27.	<b>Total</b>		136,700			32,430		

\* 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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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

Line No.	Description	Adults and Pediatrics	Sub I Mental Health Care	Sub II Un Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 542.81	\$ 669.00	\$ 640.10	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		776		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 519,144	\$	\$
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)	\$	\$ 519,144	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,612.07		\$
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 363.98		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 32,430
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 551,574</b>

**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> 14-0213	<b>Public Aid Provider Number:</b> 10004
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

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.	Mental Health Care Unit						
4.	Rehabilitation 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
						(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:	14-0213	Public Aid Provider Number:	10004
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 10-01-02 To: 09-30-03

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	21,917	49,475,125	0.000443	551					
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
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	50,001	7,565,605	0.006609	1,334			9		
17.	EEG	10,000	896,637	0.011153	320			4		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Outpatient Mental Health Unit									
23.01	Diabetes Center									
23.02										
23.03										
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	298,350	19,696,917	0.015147	25,382			384		
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	335,675	47,639	7.05						
28.	Mental Health Care Unit	49,000	2,825	17.35	776			13,464		
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							13,861		

\* 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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	551,574		
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)	13,861		
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>	565,435		
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)	136,700
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Mental Health Care Unit	548,176
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	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>	684,876
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	119,441
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**

<b>Medicare Provider Number:</b> 14-0213	<b>Public Aid Provider Number:</b> 10004
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

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)	565,435		
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)	565,435		
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>	565,435		

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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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)	119,441
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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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 Mental Health Ca	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 Mental Health Ca	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 Mental Health Ca	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**

<b>Medicare Provider Number:</b> 14-0213	<b>Public Aid Provider Number:</b> 10004
<b>Program:</b> Medicaid-Psychiatric	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	14,742,241	49,475,125	0.297973
2.	Recovery Room	1,243,884	5,159,080	0.241106
3.	Delivery and Labor Room	4,434,326	3,987,128	1.112160
4.	Anesthesiology	918,057	9,421,752	0.097440
5.	Radiology - Diagnostic	14,755,721	62,061,596	0.237759
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	8,985,968	65,473,822	0.137245
9.	Blood			
10.	Blood - Administration	1,022,519	3,131,400	0.326537
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,481,400	8,538,169	0.173503
13.	Physical Therapy	2,814,347	5,121,620	0.549503
14.	Occupational Therapy	783,598	1,688,405	0.464105
15.	Speech Pathology	357,800	323,585	1.105737
16.	EKG	1,756,515	7,565,605	0.232171
17.	EEG	373,789	896,637	0.416879
18.	Med. / Surg. Supplies	1,691,413	20,352,094	0.083108
19.	Drugs Charged to Patients	9,838,734	30,851,338	0.318908
20.	Renal Dialysis	7,729,259	25,944,071	0.297920
21.	Ambulance			
22.	Ultrasound	1,604,491	8,104,910	0.197965
23.	Outpatient Mental Health Unit	886,267	748,816	1.183558
23.01	Diabetes Center	323,427	189,724	1.704724
23.02				
23.03				
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	516,853	287,860	1.795501
25.	Emergency	7,495,805	19,696,917	0.380557
26.	Observation Beds (Non-distinct Part)	1,722,336	2,218,195	0.776458
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	25,858,694	47,639	542.81
28.	Mental Health Care Unit	1,889,938	2,825	669.00
29.	Rehabilitation Unit	2,884,933	4,507	640.10
30.				
31.	Intensive Care Unit	6,162,949	3,823	1,612.07
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,443,900	3,967	363.98

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

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-02 To: 09-30-03

<b>Inpatient Reconciliation</b>	<b>Provider's Records</b>	<b>Adjustments</b>	<b>Audited Cost Report</b>
Adult Days	776		776
Newborn Days			
Total Inpatient Revenue	684,876		684,876
Ancillary Revenue	136,700		136,700
Routine Revenue	548,176		548,176
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:**

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.