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: Rush-Presbyterian-St. Luke's Medical Center	Medicare Provider Number: 14-0119
Street: 1753 West Congress Parkway	Public Aid Provider Number: 3048
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)			
	Church		Individual		State		Township
XXXX XXXX	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)

	Medicaid Hospital	XXXX XXXX	Medicaid Sub II Psychiatric Unit		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)) Rush-Presbyterian-St. Luke's 3048 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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 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	342	124,830	80,631	87,420	70.03%				
2.	Rehabilitation Unit	40	14,600	3,917	11,087	75.94%		1,146	9.67	
3.	Psychiatric Unit	95	34,675	16,057	20,874	60.20%		1,931	10.81	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU	38	13,868		9,448	68.13%				
8.	Medical ICU	53	19,345		8,479	43.83%				
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	31	11,315		3,464	30.61%				
16.	Total	599	218,633	100,605	140,772	64.39%		3,077	44.62	
17.	Observation Bed Days				1,595					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit									
3.	Psychiatric Unit			5,706	6,194			627	9.88	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU									
8.	Medical ICU									
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	**Total**			5,706	6,194	4.40%		627	9.88	

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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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 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	0.380598	22,222			8,458		
2.	Recovery Room	0.328056	73,689			24,174		
3.	Delivery and Labor Room	0.507866	10,199			5,180		
4.	Anesthesiology	0.167983	83,686			14,058		
5.	Radiology - Diagnostic	0.293965	165,567			48,671		
6.	Radiology - Therapeutic	0.291748	2,844			830		
7.	Radioisotope	0.251496	6,585			1,656		
8.	Laboratory	0.243768	696,481			169,780		
9.	Blood							
10.	Blood - Administration	0.344655	3,030			1,044		
11.	Intravenous Therapy	0.230996	27,681			6,394		
12.	Respiratory Therapy	0.323772	15,910			5,151		
13.	Physical Therapy	0.359500	8,210			2,951		
14.	Occupational Therapy	0.574216	473,499			271,891		
15.	Speech Pathology	0.900848	1,839			1,657		
16.	EKG	0.361727	60,338			21,826		
17.	EEG	0.455386	28,118			12,805		
18.	Med. / Surg. Supplies	0.084418	15,138			1,278		
19.	Drugs Charged to Patients	0.239510	815,887			195,413		
20.	Renal Dialysis	2.165892	4,136			8,958		
21.	Renal Dialysis Inpatient	0.342257						
22.	Behavioral Health	0.884810						
23.	Kidney Acquisition [per W/S D-6]	0.481154						
23.01	Liver Acquisition [per W/S D-6]	0.402267						
23.02	Heart Acquisition [per W/S D-6]	1.713611						
23.03	Pancreas Acquisition [per W/S D-6]	0.545431						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
	Outpatient Service Cost Centers							
24.	Clinic	0.558516	165			92		
25.	Emergency	0.436650	248,797			108,637		
26.	Observation Beds (Non-distinct Par	0.292456						
27.	**Total**		2,764,021			910,904		

* 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:	Public Aid Provider Number:
14-0119	3048
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	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 Rehabilitation Unit	Sub II Psychiatric Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 832.16	$ 543.52	$ 754.44	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			6,194	
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$	$ 4,673,001	$
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)			5,706	
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)	$	$	$ 4,673,001	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$		$
9.	Coronary Care Unit	$		$
10.	Surgical ICU	$ 1,633.88		$
11.	Medical ICU	$ 1,628.91		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 517.20		$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 910,904
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **5,583,905**

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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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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.	Rehabilitation Unit						
4.	Psychiatric Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Medical 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
		(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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	60,000	135,964,626	0.000441	165,567			73		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	92,777	291,321,431	0.000318	696,481			221		
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.	Renal Dialysis Inpatient									
22.	Behavioral Health	756,443	10,457,613	0.072334						
23.	Kidney Acquisition [per W/S D-6]									
23.01	Liver Acquisition [per W/S D-6]									
23.02	Heart Acquisition [per W/S D-6]									
23.03	Pancreas Acquisition [per W/S D-6]									
23.04										
23.05										
23.06										
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.	Rehabilitation Unit									
29.	Psychiatric Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Surgical ICU									
34.	Medical ICU									
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	**Total**							294		

* 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:
14-0119	3048
Program: Medicaid-Psychiatric	**Period Covered by Statement:** From: 07-01-02 To: 06-30-03

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)	5,583,905		
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)	294		
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)**	5,584,199		
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)	2,764,021
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	
	C. Psychiatric Unit	9,099,072
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Surgical ICU	
	H. Medical ICU	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	11,863,093
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	6,278,894
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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-02 To: 06-30-03

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	5,584,199		
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)	5,584,199		
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)**	5,584,199		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient	
			Organized Clinic	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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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)	6,278,894
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: 14-0119	**Public Aid Provider Number:** 3048
Program: Medicaid-Psychiatric	**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 Rehabilitation Ur**	**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 Rehabilitation Ur**	**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 Rehabilitation Ur**	**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)				
	(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 **OHF Supplement No. 2**
Graduate Medical Education Cost Adjustment Sheet
PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	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	75,796,890	199,152,085	0.380598
2.	Recovery Room	3,148,393	9,597,106	0.328056
3.	Delivery and Labor Room	6,978,472	13,740,782	0.507866
4.	Anesthesiology	7,363,063	43,832,272	0.167983
5.	Radiology - Diagnostic	39,968,867	135,964,626	0.293965
6.	Radiology - Therapeutic	5,742,626	19,683,508	0.291748
7.	Radioisotope	3,490,367	13,878,406	0.251496
8.	Laboratory	71,014,780	291,321,431	0.243768
9.	Blood			
10.	Blood - Administration	16,695,948	48,442,512	0.344655
11.	Intravenous Therapy	1,927,519	8,344,365	0.230996
12.	Respiratory Therapy	7,104,403	21,942,642	0.323772
13.	Physical Therapy	4,683,977	13,029,156	0.359500
14.	Occupational Therapy	3,565,828	6,209,910	0.574216
15.	Speech Pathology	1,884,164	2,091,544	0.900848
16.	EKG	14,173,501	39,182,841	0.361727
17.	EEG	3,237,446	7,109,237	0.455386
18.	Med. / Surg. Supplies	3,337,276	39,532,871	0.084418
19.	Drugs Charged to Patients	43,448,833	181,407,261	0.239510
20.	Renal Dialysis	1,401,319	646,994	2.165892
21.	Renal Dialysis Inpatient	1,931,675	5,643,931	0.342257
22.	Behavioral Health	9,253,003	10,457,613	0.884810
23.	Kidney Acquisition [per W/S D-6]	6,352,714	13,203,091	0.481154
23.01	Liver Acquisition [per W/S D-6]	2,409,678	5,990,252	0.402267
23.02	Heart Acquisition [per W/S D-6]	404,299	235,934	1.713611
23.03	Pancreas Acquisition [per W/S D-6]	556,726	1,020,708	0.545431
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
	Outpatient Ancillary Centers			
24.	Clinic	10,227,656	18,312,214	0.558516
25.	Emergency	14,257,449	32,651,882	0.436650
26.	Observation Beds (Non-distinct Part)	1,283,966	4,390,283	0.292456
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	74,074,797	89,015	832.16
28.	Rehabilitation Unit	6,026,004	11,087	543.52
29.	Psychiatric Unit	15,748,090	20,874	754.44
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Surgical ICU	15,436,905	9,448	1,633.88
34.	Medical ICU	13,811,532	8,479	1,628.91
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,791,593	3,464	517.20

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-02 To: 06-30-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	6,194		6,194
Newborn Days			
Total Inpatient Revenue	11,863,261	(168)	11,863,093
Ancillary Revenue	2,764,189	(168)	2,764,021
Routine Revenue	9,099,072		9,099,072
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:

There was no adjustment to the filed W/S C charges to prepare the FYE 06-30-01 and 06-30-02 OHF reports.

Determined that there was no adjustment to the filed W/S C charges to prepare the reports for this FY.

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

Joe Knapczyk agreed that the professional componentsfor OHF-6, Column 1 should be taken from the W/S A-8-2, Column 4.

Per Joe Knapczyk, total Nursery days = 3,746 - 282 boarder baby days = 3,464.

Removed $168 noncovered "Day Hospital" charges.