

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: Memorial Medical Center		Medicare Provider Number: 14-0148	
Street: 701 North First Street		Public Aid Provider Number: 19006	
City: Springfield	State: Illinois	Zip: 62781-0001	
Period Covered by Statement:	From: 10/01/03	To: 09/30/04	

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"/> XXXX XXXX Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input type="checkbox"/> XXXX XXXX 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 type="checkbox"/> XXXX XXXX Medicaid Sub I Psychiatric [Adult & Adolescent]	<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)) Memorial Medical Center 19006 for the cost report beginning 10/01/03 and ending 09/30/04 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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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	361	115,565		87,208	75.46%		19,948	4.78	
2.	Psychiatric Unit	50	18,300		12,514	68.38%		1,601	7.82	
3.	Rehabilitation Unit	30	10,980		6,330	57.65%		438	14.45	
4.										
5.	Intensive Care Unit	24	8,784		6,271	71.39%				
6.	Coronary Care Unit									
7.	Burn ICU	8	2,928		1,793	61.24%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	21	7,686		2,770	36.04%				
16.	Total	494	164,243		116,886	71.17%		21,987	5.19	
17.	Observation Bed Days				1,714					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				2,744			485	5.66	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Burn ICU									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				2,744	2.35%		485	5.66	

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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room	0.290534	4,733			1,375		
2.	Recovery Room							
3.	Delivery and Labor Room	0.476996						
4.	Anesthesiology	0.091202	7,388			674		
5.	Radiology - Diagnostic	0.218569	100,838			22,040		
6.	Radiology - Therapeutic	0.313508						
7.	Nuclear Medicine							
8.	Laboratory	0.264977	433,181			114,783		
9.	Blood							
10.	Blood - Administration	0.365925	349			128		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.245785	5,900			1,450		
13.	Physical Therapy	0.443286	34,652			15,361		
14.	Occupational Therapy	0.259680	6,606			1,715		
15.	Speech Pathology	0.439467	702			309		
16.	EKG	0.214830	34,000			7,304		
17.	EEG	0.276500	12,303			3,402		
18.	Med. / Surg. Supplies	0.397577	18,567			7,382		
19.	Drugs Charged to Patients	0.348020	184,214			64,110		
20.	Renal Dialysis	0.234315	13,330			3,123		
21.	Ambulance							
22.	GI Diagnostics Unit	0.241461	3,236			781		
23.	Vascular Lab	0.219694	1,187			261		
23.01	Ambulatory Surgery	0.310395						
23.02	Renal Transplant Lab	0.738604						
23.03	Kidney Acquisition	0.731697						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.347504	178,015			61,861		
26.	Observation Beds (Non-distinct Par	0.795763						
27.	Total		1,039,201			306,059		

* 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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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)	\$ 583.96	\$ 684.62	\$ 455.55	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		2,744		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 1,878,597	\$	\$
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)	\$	\$ 1,878,597	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,171.82		\$
9.	Coronary Care Unit	\$		\$
10.	Burn ICU	\$ 1,174.46		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 348.41		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 306,059
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,184,656

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

Medicare Provider Number: 14-0148		Public Aid Provider Number: 19006	
Program: Medicaid-Psychiatric [Adult & Adolescent]		Period Covered by Statement: From: 10/01/03 To: 09/30/04	

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.	Burn ICU						
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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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	88,657	70,405,793	0.001259	4,733			6		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	30,000	35,357,366	0.000848	7,388			6		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic	3,000	8,617,963	0.000348						
7.	Nuclear Medicine									
8.	Laboratory	400,208	80,742,515	0.004957	433,181			2,147		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	11,154	22,459,782	0.000497	5,900			3		
13.	Physical Therapy	133,822	13,308,311	0.010056	34,652			348		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	1,060,364	115,930,029	0.009147	34,000			311		
17.	EEG	6,241	1,915,071	0.003259	12,303			40		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	45,500	6,149,394	0.007399	13,330			99		
21.	Ambulance									
22.	GI Diagnostics Unit	15,000	9,139,764	0.001641	3,236			5		
23.	Vascular Lab									
23.01	Ambulatory Surgery									
23.02	Renal Transplant Lab	36,000	729,429	0.049354						
23.03	Kidney Acquisition									
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency	1,024,573	22,795,894	0.044946	178,015			8,001		
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	48,615	88,922	0.55						
28.	Psychiatric Unit	25,523	12,514	2.04	2,744			5,598		
29.	Rehabilitation Unit	1,500	6,330	0.24						
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Burn ICU									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	105,186	2,770	37.97						
37.	Total							16,564		

* 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: 14-0148		Public Aid Provider Number: 19006		
Program: Medicaid-Psychiatric [Adult & Adolescent]		Period Covered by Statement: From: 10/01/03 To: 09/30/04		
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)	2,184,656		
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)	16,564		
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)	2,201,220		
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)	1,039,201
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	2,293,088
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Burn ICU	
	H.	
	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)	3,332,289
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,131,069
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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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)	2,201,220		
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)	2,201,220		
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)	2,201,220		

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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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)	1,131,069
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.	Total (Sum of Lines 1 - 3)							

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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	20,455,267	70,405,793	0.290534
2.	Recovery Room			
3.	Delivery and Labor Room	2,956,968	6,199,152	0.476996
4.	Anesthesiology	3,224,653	35,357,366	0.091202
5.	Radiology - Diagnostic	23,365,597	106,902,563	0.218569
6.	Radiology - Therapeutic	2,701,797	8,617,963	0.313508
7.	Nuclear Medicine			
8.	Laboratory	21,394,906	80,742,515	0.264977
9.	Blood			
10.	Blood - Administration	3,772,589	10,309,738	0.365925
11.	Intravenous Therapy			
12.	Respiratory Therapy	5,520,269	22,459,782	0.245785
13.	Physical Therapy	5,899,387	13,308,311	0.443286
14.	Occupational Therapy	1,280,173	4,929,812	0.259680
15.	Speech Pathology	938,107	2,134,647	0.439467
16.	EKG	24,905,277	115,930,029	0.214830
17.	EEG	529,517	1,915,071	0.276500
18.	Med. / Surg. Supplies	22,669,930	57,020,272	0.397577
19.	Drugs Charged to Patients	20,128,254	57,836,438	0.348020
20.	Renal Dialysis	1,440,894	6,149,394	0.234315
21.	Ambulance			
22.	GI Diagnostics Unit	2,206,898	9,139,764	0.241461
23.	Vascular Lab	715,088	3,254,930	0.219694
23.01	Ambulatory Surgery	4,903,661	15,798,134	0.310395
23.02	Renal Transplant Lab	538,759	729,429	0.738604
23.03	Kidney Acquisition	1,241,710	1,697,028	0.731697
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	7,921,660	22,795,894	0.347504
26.	Observation Beds (Non-distinct Part)	938,995	1,179,993	0.795763
Routine Service Cost Centers				
27.	Adults and Pediatrics	51,926,665	88,922	583.96
28.	Psychiatric Unit	8,567,329	12,514	684.62
29.	Rehabilitation Unit	2,883,607	6,330	455.55
30.				
31.	Intensive Care Unit	7,348,513	6,271	1,171.82
32.	Coronary Care Unit			
33.	Burn ICU	2,105,814	1,793	1,174.46
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	965,107	2,770	348.41

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

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric [Adult & Adolescent]	Period Covered by Statement: From: 10/01/03 To: 09/30/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,744		2,744
Newborn Days			
Total Inpatient Revenue	3,332,369	(80)	3,332,289
Ancillary Revenue	1,039,281	(80)	1,039,201
Routine Revenue	2,293,088		2,293,088
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:

3A, Adolescent Psych: #Beds = 15; # Bed Days Available = 15 X 366= 5,490; Utilization = 2,695; Discharges = 345

3A Medicaid Utilization for Adolescent Psych = 1,522; Discharges = 485 - 246 adult psych per filed W/S S-3 = 239

Medicaid Psych Utilization = 1,222 adult psych + 1,522 adolescent psych = 2,744; Medicaid Psych discharges = 485

Total hospital discharges = 20,557 per W/S S-3 - 264 per Children's report - 345 adolescent psych = 19,948.

Determined that filed OHF Supplement No. 2 charges for Anesthesiology, Physical Therapy, EKG, Medical Supplies and ER are greater than the filed W/S C charges.

Removed Cardiac Rehab charges of \$80 which are non-covered for Illinois Medicaid.
