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: Mercy Hospital & Medical Center	Medicare Provider Number: 14-0158
Street: 2525 South Michigan Avenue	Public Aid Provider Number: 3042
City: Chicago / State: Illinois	Zip: 60616-2477
Period Covered by Statement: From: 07-01-03	To: 06-30-04

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		Medicaid Sub II		DHS - Office of Rehabilitation Services
XXXX XXXX	Medicaid Sub I Psychiatric		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)) Mercy Hospital & Medical Cer 3042 for the cost report beginning 07-01-03 and ending 06-30-04 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)	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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	244	89,304		34,544	38.68%		12,903	3.31	
2.	Psychiatric Unit	29	10,614		6,247	58.86%		986	6.34	
3.	Rehabilitation Unit	24	8,784		5,465	62.22%		578	9.46	
4.										
5.	Intensive Care Unit	14	5,124		4,197	81.91%				
6.	Coronary Care Unit	6	2,196		1,684	76.68%				
7.	Nursery ICU/Special Care Nursery	15	5,490		2,331	42.46%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	28	10,248		3,074	30.00%				
16.	Total	360	131,760		57,542	43.67%		14,467	3.76	
17.	Observation Bed Days				1,181					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				4,007			734	5.46	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Nursery ICU/Special Care Nursery									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	**Total**				4,007	6.96%		734	5.46	

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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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	0.352112						
2.	Recovery Room	0.249622						
3.	Delivery and Labor Room	0.205237	5,583			1,146		
4.	Anesthesiology	0.123387						
5.	Radiology - Diagnostic	0.202538	44,828			9,079		
6.	Radiology - Therapeutic	0.130481	2,118			276		
7.	Nuclear Medicine	0.133460	1,862			249		
8.	Laboratory	0.160086	538,062			86,136		
9.	Diabetes Treatment Center	0.144495						
10.	Doctors Office Center	0.734096						
11.	Mercy Rheumatology Center							
12.	Respiratory Therapy	0.159792	806			129		
13.	Physical Therapy	0.267247	1,589			425		
14.	Occupational Therapy	0.343089	170,242			58,408		
15.	Speech Pathology	0.396033						
16.	Peds Practice	0.139627						
17.	EEG	0.377299	3,151			1,189		
18.	Med. / Surg. Supplies	0.669353	750			502		
19.	Drugs Charged to Patients	0.276809	418,079			115,728		
20.	Renal Dialysis	0.183693						
21.	Ambulance							
22.	G.I. Lab	0.232534						
23.	MRI Center	0.119683	2,736			327		
23.01	Pulmonary Rehab	8.752979						
23.02	ASC (Non-distinct Part)	4.921633						
23.03	Urology Services	0.679743						
23.04	Industrial Nursing	0.960172						
23.05	Audiology	33.988846						
23.06	Electrodiagnosis [EMG]	0.105925						
23.07	Cardiovascular Labs	0.174652	70,472			12,308		
23.08	Mercy Eye Center	0.615325						
23.09	Wound Management	0.326952						
	Outpatient Service Cost Centers							
24.	Clinic	0.835441						
25.	Emergency	0.323714	311,218			100,746		
26.	Observation Beds (Non-distinct Par	0.303461						
27.	**Total**		1,571,496			386,648		

* 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.

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Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	$ 758.01	$ 491.05	$ 374.93	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		4,007		
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$ 1,967,637	$	$
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)	$	$ 1,967,637	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,187.50		$
9.	Coronary Care Unit	$ 899.10		$
10.	Nursery ICU/Special Care Nursery	$ 577.71		$
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 253.76		$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 386,648
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			**$ 2,354,285**

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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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (HCFA 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Nursery ICU/Special Care Nurse						
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 Assign-able Time (HCFA 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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)**										

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

PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Diabetes Treatment Center									
10.	Doctors Office Center									
11.	Mercy Rheumatology Center									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	Peds Practice									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	G.I. Lab									
23.	MRI Center									
23.01	Pulmonary Rehab									
23.02	ASC (Non-distinct Part)									
23.03	Urology Services									
23.04	Industrial Nursing									
23.05	Audiology									
23.06	Electrodiagnosis [EMG]									
23.07	Cardiovascular Labs									
23.08	Mercy Eye Center									
23.09	Wound Management									
	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.	Nursery ICU/Special Care Nursery									
34.										
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:	Public Aid Provider Number:
14-0158	3042
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 07-01-03 To: 06-30-04

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)	2,354,285		
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)**	2,354,285		
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)	1,571,496
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	4,453,855
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Nursery ICU/Special Care Nursery	
	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)**	6,025,351
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	3,671,066
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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	2,354,285		
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)	2,354,285		
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)**	2,354,285		

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: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	3,671,066
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: 14-0158	**Public Aid Provider Number:** 3042
Program: Medicaid-Psychiatric	**Period Covered by Statement:** From: 07-01-03 To: 06-30-04

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 **OHF Supplement No. 2**
Graduate Medical Education Cost Adjustment Sheet
PRELIMINARY

Medicare Provider Number: 14-0158	Public Aid Provider Number: 3042
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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	10,562,167	29,996,581	0.352112
2.	Recovery Room	629,733	2,522,751	0.249622
3.	Delivery and Labor Room	3,242,147	15,797,126	0.205237
4.	Anesthesiology	558,029	4,522,585	0.123387
5.	Radiology - Diagnostic	9,243,970	45,640,590	0.202538
6.	Radiology - Therapeutic	708,624	5,430,841	0.130481
7.	Nuclear Medicine	697,494	5,226,246	0.133460
8.	Laboratory	8,227,808	51,396,111	0.160086
9.	Diabetes Treatment Center	44,902	310,752	0.144495
10.	Doctors Office Center	308,664	420,468	0.734096
11.	Mercy Rheumatology Center			
12.	Respiratory Therapy	1,654,619	10,354,862	0.159792
13.	Physical Therapy	958,082	3,585,009	0.267247
14.	Occupational Therapy	1,073,265	3,128,243	0.343089
15.	Speech Pathology	170,779	431,224	0.396033
16.	Peds Practice	36,405	260,731	0.139627
17.	EEG	104,624	277,297	0.377299
18.	Med. / Surg. Supplies	3,070,745	4,587,629	0.669353
19.	Drugs Charged to Patients	9,676,131	34,956,039	0.276809
20.	Renal Dialysis	696,361	3,790,904	0.183693
21.	Ambulance			
22.	G.I. Lab	767,472	3,300,467	0.232534
23.	MRI Center	1,025,468	8,568,221	0.119683
23.01	Pulmonary Rehab	347,502	39,701	8.752979
23.02	ASC (Non-distinct Part)	1,485,285	301,787	4.921633
23.03	Urology Services	62,743	92,304	0.679743
23.04	Industrial Nursing	363,137	378,200	0.960172
23.05	Audiology	88,371	2,600	33.988846
23.06	Electrodiagnosis [EMG]	66,578	628,540	0.105925
23.07	Cardiovascular Labs	6,553,816	37,524,905	0.174652
23.08	Mercy Eye Center	627,939	1,020,499	0.615325
23.09	Wound Management	520,878	1,593,134	0.326952
	Outpatient Ancillary Centers			
24.	Clinic	4,755,166	5,691,805	0.835441
25.	Emergency	7,147,888	22,080,877	0.323714
26.	Observation Beds (Non-distinct Part)	715,119	2,356,545	0.303461
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	27,079,792	35,725	758.01
28.	Psychiatric Unit	3,067,620	6,247	491.05
29.	Rehabilitation Unit	2,048,986	5,465	374.93
30.				
31.	Intensive Care Unit	4,983,935	4,197	1,187.50
32.	Coronary Care Unit	1,514,087	1,684	899.10
33.	Nursery ICU/Special Care Nursery	1,346,635	2,331	577.71
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	780,067	3,074	253.76

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0158	3042
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 07-01-03 To: 06-30-04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,007		4,007
Newborn Days			
Total Inpatient Revenue	6,025,351		6,025,351
Ancillary Revenue	1,571,496		1,571,496
Routine Revenue	4,453,855		4,453,855
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

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