

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: 07-01-03	To: 06-30-04	

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 checked="" type="checkbox"/> Corporation XXXX XXXX	<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 XXXX XXXX	<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 checked="" type="checkbox"/> Medicaid Sub II XXXX XXXX	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Rush-Presbyterian-St. Luke's 3048 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)
 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: 14-0119	Public Aid Provider Number: 3048
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 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	342	125,172	87,400	96,630	77.20%				
2.	Rehabilitation Unit	40	14,640	3,964	11,648	79.56%		1,211	9.62	
3.	Psychiatric Unit	92	33,672	15,569	20,802	61.78%		1,920	10.83	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU	42	15,372		10,057	65.42%				
8.	Medical ICU	51	18,666		8,771	46.99%				
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	21	7,686		3,827	49.79%				
16.	Total	588	215,208	106,933	151,735	70.51%		3,131	47.24	
17.	Observation Bed Days				1,198					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit									
3.	Psychiatric Unit			5,496	5,546			426	13.02	
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			5,496	5,546	3.66%		426	13.02	

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: 07-01-03 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	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	0.358473	15,559			5,577		
2.	Recovery Room	0.296586	66,580			19,747		
3.	Delivery and Labor Room	0.459583	4,920			2,261		
4.	Anesthesiology	0.147491	66,379			9,790		
5.	Radiology - Diagnostic	0.260712	123,987			32,325		
6.	Radiology - Therapeutic	0.229097						
7.	Radioisotope	0.254213	6,562			1,668		
8.	Laboratory	0.215785	690,793			149,063		
9.	Blood							
10.	Blood - Administration	0.305549	63,359			19,359		
11.	Intravenous Therapy	0.214575	26,408			5,666		
12.	Respiratory Therapy	0.345923	1,857			642		
13.	Physical Therapy	0.368083	5,900			2,172		
14.	Occupational Therapy	0.675511	164,027			110,802		
15.	Speech Pathology	0.810998	1,134			920		
16.	EKG	0.317515	57,270			18,184		
17.	EEG	0.447656	33,171			14,849		
18.	Med. / Surg. Supplies	0.071672	13,177			944		
19.	Drugs Charged to Patients	0.203471	751,724			152,954		
20.	Renal Dialysis	2.416995						
21.	Renal Dialysis Inpatient	0.327291	1,410			461		
22.	Behavioral Health	0.841941						
23.	Kidney Acquisition [per W/S D-6]	0.457748						
23.01	Liver Acquisition [per W/S D-6]	0.417333						
23.02	Heart Acquisition [per W/S D-6]	0.475741						
23.03	Pancreas Acquisition [per W/S D-6]	0.870752						
23.04	Psych Day Hospital	1.317997	606			799		
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic	0.634609	91			58		
25.	Emergency	0.443982	216,265			96,018		
26.	Observation Beds (Non-distinct Par	0.215956						
27.	Total		2,311,179			644,259		

* 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: 14-0119	Public Aid Provider Number: 3048
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 Rehabilitation Unit	Sub II Psychiatric Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 826.12	\$ 635.75	\$ 848.99	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			5,546	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 4,708,499	\$
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)			5,496	
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)	\$	\$	\$ 4,708,499	\$

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	\$ 1,776.25		\$
11.	Medical ICU	\$ 1,717.07		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 520.99		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 644,259
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 5,352,758

**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: 07-01-03 To: 06-30-04

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.	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
						(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:	14-0119	Public Aid Provider Number:	3048
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.	Radioisotope									
8.	Laboratory	15,833	345,258,793	0.000046	690,793			32		
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									
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	Psych Day Hospital									
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic	123,762	20,640,003	0.005996	91			1		
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							33		

* 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: 14-0119	Public Aid Provider Number: 3048
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-03 To: 06-30-04

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)	5,352,758		
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)	33		
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)	5,352,791		
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)	2,311,179
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	
	C. Psychiatric Unit	8,908,429
	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)	11,219,608
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	5,866,817
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: 07-01-03 To: 06-30-04

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)	5,352,791		
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)	5,352,791		
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)	5,352,791		

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: 14-0119	Public Aid Provider Number: 3048
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)	5,866,817
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	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(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
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3048
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 Rehabilitation Unit	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 Unit	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 Unit	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
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3048
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	87,395,203	243,798,350	0.358473
2.	Recovery Room	3,376,274	11,383,808	0.296586
3.	Delivery and Labor Room	7,206,126	15,679,708	0.459583
4.	Anesthesiology	7,396,602	50,149,605	0.147491
5.	Radiology - Diagnostic	37,837,358	145,130,946	0.260712
6.	Radiology - Therapeutic	6,921,691	30,212,869	0.229097
7.	Radioisotope	4,226,575	16,626,110	0.254213
8.	Laboratory	74,501,710	345,258,793	0.215785
9.	Blood			
10.	Blood - Administration	16,636,270	54,447,168	0.305549
11.	Intravenous Therapy	2,007,124	9,353,937	0.214575
12.	Respiratory Therapy	8,032,401	23,220,168	0.345923
13.	Physical Therapy	5,066,111	13,763,501	0.368083
14.	Occupational Therapy	3,684,877	5,454,950	0.675511
15.	Speech Pathology	2,138,644	2,637,053	0.810998
16.	EKG	13,256,490	41,750,718	0.317515
17.	EEG	4,263,467	9,523,988	0.447656
18.	Med. / Surg. Supplies	3,361,916	46,906,663	0.071672
19.	Drugs Charged to Patients	43,702,505	214,785,456	0.203471
20.	Renal Dialysis	1,374,613	568,728	2.416995
21.	Renal Dialysis Inpatient	2,262,402	6,912,506	0.327291
22.	Behavioral Health	9,469,544	11,247,283	0.841941
23.	Kidney Acquisition [per W/S D-6]	6,703,482	14,644,466	0.457748
23.01	Liver Acquisition [per W/S D-6]	3,938,280	9,436,783	0.417333
23.02	Heart Acquisition [per W/S D-6]	688,328	1,446,853	0.475741
23.03	Pancreas Acquisition [per W/S D-6]	181,645	208,607	0.870752
23.04	Psych Day Hospital	3,791,429	2,876,660	1.317997
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic	13,098,323	20,640,003	0.634609
25.	Emergency	16,398,679	36,935,462	0.443982
26.	Observation Beds (Non-distinct Part)	960,150	4,446,054	0.215956
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	80,817,233	97,828	826.12
28.	Rehabilitation Unit	7,405,269	11,648	635.75
29.	Psychiatric Unit	17,660,617	20,802	848.99
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Surgical ICU	17,863,760	10,057	1,776.25
34.	Medical ICU	15,060,450	8,771	1,717.07
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,993,841	3,827	520.99

**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: 07-01-03 To: 06-30-04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,546		5,546
Newborn Days			
Total Inpatient Revenue	11,219,608		11,219,608
Ancillary Revenue	2,311,179		2,311,179
Routine Revenue	8,908,429		8,908,429
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:

- Adjusted Routine Days to match W/S S-3 with splits between Acute and Children's facilities.
- Adjusted Surgical ICU and Medical ICU Total Days to match W/S S-3 (10,057 and 8771).
- Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.