Hospital Statement of Cost

Illinois Department of Public Aid, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Silver Cross Hospital	Medicare Provider Number: 14-0213
Street: 1200 Maple Road	Public Aid Provider Number: 10004
City: Joliet / State: Illinois	Zip: 60432
Period Covered by Statement: From: 10/01/03	To: 09/30/04

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	XXXX XXXX	Medicaid Sub II Rehabilitation 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)) Silver Cross Hospital 10004 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):

Name (Typewritten)
Title Date
Firm
Telephone Number

Signed (Officer or Administrator of Provider(s)):

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.

Rev. 1 / 99

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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	239	87,474		45,499	52.01%		13,838	3.58	
2.	Psychiatric Unit	20	7,320		3,002	41.01%		752	3.99	
3.	Rehabilitation Unit	20	7,320		4,884	66.72%		385	12.69	
4.	Sub III									
5.	Intensive Care Unit	18	6,588		4,017	60.97%				
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	26	9,490		4,322	45.54%				
16.	Total	323	118,192		61,724	52.22%		14,975	3.83	
17.	Observation Bed Days				3,909					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit									
3.	Rehabilitation Unit				38			4	9.50	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	**Total**				38	0.06%		4	9.50	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	**Total Emergency and Private Referred (Sum of Lines 2 and 3)**			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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)	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	0.164345	5,304			872		
2.	Recovery Room	0.203208	997			203		
3.	Delivery and Labor Room	0.913279						
4.	Anesthesiology	0.059559	116			7		
5.	Radiology - Diagnostic	0.181669	22,475			4,083		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.128852	110,029			14,177		
9.	Blood							
10.	Blood - Administration	0.347935	11,045			3,843		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.164271	24,228			3,980		
13.	Physical Therapy	0.593793						
14.	Occupational Therapy	0.292472	15,501			4,534		
15.	Speech Pathology	0.873353	1,758			1,535		
16.	EKG	0.137628	2,197			302		
17.	EEG	0.460368	965			444		
18.	Med. / Surg. Supplies	0.472235	124,223			58,662		
19.	Drugs Charged to Patients	0.290378	178,649			51,876		
20.	Renal Dialysis	0.302987	6,029			1,827		
21.	Ambulance							
22.	Ultrasound	0.204652	10,977			2,246		
23.	Diabetes Center	1.698612	1,337			2,271		
23.01	Other							
23.02	Other							
23.03	Other							
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic	2.258783						
25.	Emergency	0.351631	575			202		
26.	Mental Health Unit	1.341705						
27.	**Total**		516,405			151,064		

* 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.

Rev. 1 / 99

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	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 Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 580.19	$ 672.44	$ 763.44	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			38	
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$	$ 29,011	$
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 (BHF 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)	$	$	$ 29,011	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 1,669.18		$
9.	Coronary Care Unit	$		$
10.	Other	$		$
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 399.13		$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 151,064
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **180,075**

Rev. 1 / 99

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

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/03 To: 09/30/04

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 (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF 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.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
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.	Mental Health Unit										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	**Total (Sum of Lines 12 and 16)**										

Rev. 1 / 99

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

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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 (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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	34,667	55,392,709	0.000626	5,304			3		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	1,720	9,268,266	0.000186	24,228			5		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	50,000	7,360,178	0.006793	2,197			15		
17.	EEG	60,000	885,499	0.067758	965			65		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Diabetes Center									
23.01	Other									
23.02	Other									
23.03	Other									
23.04	Other									
23.05	Other									
23.06	Other									
23.07	Other									
23.08	Other									
23.09	Other									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	300,400	21,372,719	0.014055	575			8		
26.	Mental Health Unit									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	308,798	49,408	6.25						
28.	Psychiatric Unit	3,578	3,002	1.19						
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	**Total**							96		

* 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:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 10/01/03 To: 09/30/04

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	180,075		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)	96		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)**	180,171		
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)	516,405
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	
	C. Rehabilitation Unit	27,520
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	543,925
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	363,754
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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/03 To: 09/30/04

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	180,171		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	180,171		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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)**	180,171		

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.

Rev. 1 / 99

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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 (BHF Page 7, Line 12)	363,754
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 (BHF 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
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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 Sub III
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6.	Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

	Part C. Program Cost	General Service	Sub I Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
7.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8.	Program organized clinic cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				
9.	Program referred outpatient cost (Line 6 X Line 3) (to BHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	1. Gross Routine Revenues	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Ur	Sub III Sub III
	(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 BHF 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 BHF Page 4, Line 1)**				

Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Rehabilitation	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 BHF pgs. 3-4)
	Inpatient Ancillary Centers			
1.	Operating Room	9,103,507	55,392,709	0.164345
2.	Recovery Room	1,240,201	6,103,105	0.203208
3.	Delivery and Labor Room	4,078,254	4,465,507	0.913279
4.	Anesthesiology	618,659	10,387,374	0.059559
5.	Radiology - Diagnostic	12,071,601	66,448,430	0.181669
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	9,338,518	72,475,011	0.128852
9.	Blood			
10.	Blood - Administration	1,151,421	3,309,295	0.347935
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,522,510	9,268,266	0.164271
13.	Physical Therapy	2,649,894	4,462,657	0.593793
14.	Occupational Therapy	578,417	1,977,686	0.292472
15.	Speech Pathology	293,981	336,612	0.873353
16.	EKG	1,012,968	7,360,178	0.137628
17.	EEG	407,655	885,499	0.460368
18.	Med. / Surg. Supplies	9,906,788	20,978,499	0.472235
19.	Drugs Charged to Patients	9,517,875	32,777,490	0.290378
20.	Renal Dialysis	9,406,647	31,046,375	0.302987
21.	Ambulance			
22.	Ultrasound	1,912,724	9,346,245	0.204652
23.	Diabetes Center	326,925	192,466	1.698612
23.01	Other			
23.02	Other			
23.03	Other			
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic	551,579	244,193	2.258783
25.	Emergency	7,515,309	21,372,719	0.351631
26.	Mental Health Unit	957,093	713,341	1.341705
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	28,665,781	49,408	580.19
28.	Psychiatric Unit	2,018,652	3,002	672.44
29.	Rehabilitation Unit	3,728,628	4,884	763.44
30.	Sub III			
31.	Intensive Care Unit	6,705,084	4,017	1,669.18
32.	Coronary Care Unit			
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,725,036	4,322	399.13

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 10/01/03 To: 09/30/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	38		38
Newborn Days			
Total Inpatient Revenue	543,925		543,925
Ancillary Revenue	516,405		516,405
Routine Revenue	27,520		27,520
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 2 charges match the Medicare W/S C charges.