

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: Barnes-Jewish Hospital		Medicare Provider Number: 26-0032	
Street: One Barnes-Jewish Hospital Plaza		Public Aid Provider Number: 19014	
City: St. Louis	State: Missouri	Zip: 63110	
Period Covered by Statement:	From: 01/01/05	To: 12/31/05	

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

Type of Hospital

<input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<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)) Barnes-Jewish Hospital 19014 for the cost report beginning 01/01/05 and ending 12/31/05 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	1,098	393,656	24,299	234,693	59.62%		51,061	5.28	
2.	Psychiatric Unit	61	22,512	292	16,317	72.48%		1,699	9.60	
3.										
4.										
5.	Intensive Care Unit	29	10,585		9,526	90.00%				
6.	Coronary Care Unit	15	5,475		4,506	82.30%				
7.	Surgical ICU	24	8,760		7,588	86.62%				
8.	Neuro ICU	20	7,300		6,082	83.32%				
9.	Cardiothoracic ICU	29	10,585		7,237	68.37%				
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	24	8,760		6,912	78.90%				
16.	Total	1,300	467,633	24,591	292,861	62.63%		52,760	5.42	
17.	Observation Bed Days				392					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				7,496			1,423	6.13	
2.	Psychiatric Unit									
3.										
4.										
5.	Intensive Care Unit				376					
6.	Coronary Care Unit				171					
7.	Surgical ICU				324					
8.	Neuro ICU				196					
9.	Cardiothoracic ICU				154					
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				213					
16.	Total				8,930	3.05%		1,423	6.13	

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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	0.458799	4,335,544			1,989,143		
2.	Recovery Room	0.490499	325,889			159,848		
3.	Delivery and Labor Room	0.440844						
4.	Anesthesiology	0.358364	562,220			201,479		
5.	Radiology - Diagnostic	0.264021	2,525,757			666,853		
6.	Radiology - Therapeutic	0.273607	232,460			63,603		
7.	Radioisotope	0.259404	108,650			28,184		
8.	Laboratory	0.150781	5,988,725			902,986		
9.	Blood							
10.	Blood - Administration	0.245885	2,860,876			703,446		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.186531	2,340,360			436,550		
13.	Physical Therapy	0.430832	215,053			92,652		
14.	Occupational Therapy	0.336923	132,766			44,732		
15.	Speech Pathology	0.422360	33,209			14,026		
16.	EKG	0.114217	745,942			85,199		
17.	EEG	0.281072	140,339			39,445		
18.	Med. / Surg. Supplies	0.337600	2,014,422			680,069		
19.	Drugs Charged to Patients	0.266248	8,598,514			2,289,337		
20.	Renal Dialysis	0.333278	245,585			81,848		
21.	Ambulance							
22.	HLA Lab	0.318763	19,623			6,255		
23.	CT Scan	0.063802	1,341,220			85,573		
23.01	Ultrasound	0.159133	198,395			31,571		
23.02	Cardiac Catheterization Laboratory	0.328586	1,496,332			491,674		
23.03	Endoscopy	0.339399	271,989			92,313		
23.04	OB/ Gyn In-Vitro	0.835769						
23.05	O/P Pharmacy	1.383352						
23.06	Electroshock Therapy	0.511271						
23.07	O/P Psych	0.723355						
23.08	Lung Acquisition [from W/S D-6]	0.734015	99,200			72,814		
23.09								
Outpatient Service Cost Centers								
24.	Clinic	1.967382	16,526			32,513		
25.	Emergency	0.532736	401,628			213,962		
26.	Observation Beds (Non-distinct Par	0.910214						
27.	Total		35,251,224			9,506,075		

* 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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 860.78	\$ 780.93	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	7,496			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 6,452,407	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$ 11.63	\$	\$
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)	\$ 6,452,407	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,991.81	376	\$ 748,921
9.	Coronary Care Unit	\$ 1,211.44	171	\$ 207,156
10.	Surgical ICU	\$ 1,496.50	324	\$ 484,866
11.	Neuro ICU	\$ 1,296.75	196	\$ 254,163
12.	Cardiothoracic ICU	\$ 1,438.59	154	\$ 221,543
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 255.92	213	\$ 54,511
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 9,506,075
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 17,929,642

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

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Neuro ICU						
10.	Cardiothoracic ICU						
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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									
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.	Ambulance									
22.	HLA Lab									
23.	CT Scan									
23.01	Ultrasound									
23.02	Cardiac Catheterization Laboratory									
23.03	Endoscopy									
23.04	OB/ Gyn In-Vitro									
23.05	O/P Pharmacy									
23.06	Electroshock Therapy									
23.07	O/P Psych									
23.08	Lung Acquisition [from W/S D-6]									
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Surgical ICU									
34.	Neuro ICU									
35.	Cardiothoracic ICU									
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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)	17,929,642		
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)	17,929,642		
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)	35,251,224
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	7,289,515
	B. Psychiatric Unit	
	C.	
	D.	
	E. Intensive Care Unit	613,082
	F. Coronary Care Unit	266,730
	G. Surgical ICU	556,700
	H. Neuro ICU	337,770
	I. Cardiothoracic ICU	256,806
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	88,234
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	44,660,061
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	26,730,419
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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)	17,929,642		
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)	17,929,642		
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)	17,929,642		

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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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)	26,730,419
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)		
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)
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: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	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	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	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)		10,002,897		
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)		9,821,273		
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)		181,624		
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)		16,025		
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)		292		
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)		622.00		
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)		612.87		
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)		9.13		
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))		11.63		
7. Private room cost differential adjustment (Line 2B X Line 6)		3,396		
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)		12,742,403		
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)		780.93		

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	152,764,305	332,965,864	0.458799
2.	Recovery Room	16,714,335	34,076,182	0.490499
3.	Delivery and Labor Room	9,711,757	22,029,923	0.440844
4.	Anesthesiology	14,861,435	41,470,244	0.358364
5.	Radiology - Diagnostic	54,159,410	205,132,998	0.264021
6.	Radiology - Therapeutic	19,405,995	70,926,587	0.273607
7.	Radioisotope	4,815,662	18,564,316	0.259404
8.	Laboratory	45,839,671	304,014,707	0.150781
9.	Blood			
10.	Blood - Administration	24,578,786	99,960,529	0.245885
11.	Intravenous Therapy			
12.	Respiratory Therapy	12,195,615	65,381,145	0.186531
13.	Physical Therapy	5,196,581	12,061,734	0.430832
14.	Occupational Therapy	1,783,323	5,292,969	0.336923
15.	Speech Pathology	571,229	1,352,470	0.422360
16.	EKG	7,436,341	65,107,030	0.114217
17.	EEG	1,098,187	3,907,141	0.281072
18.	Med. / Surg. Supplies	21,770,143	64,485,092	0.337600
19.	Drugs Charged to Patients	81,130,938	304,719,970	0.266248
20.	Renal Dialysis	3,121,302	9,365,460	0.333278
21.	Ambulance			
22.	HLA Lab	1,897,430	5,952,483	0.318763
23.	CT Scan	7,740,251	121,317,647	0.063802
23.01	Ultrasound	2,808,880	17,651,105	0.159133
23.02	Cardiac Catheterization Laboratory	40,014,447	121,777,694	0.328586
23.03	Endoscopy	9,139,624	26,928,874	0.339399
23.04	OB/ Gyn In-Vitro	2,117,997	2,534,188	0.835769
23.05	O/P Pharmacy	18,447,082	13,335,061	1.383352
23.06	Electroshock Therapy	519,358	1,015,817	0.511271
23.07	O/P Psych	2,728,913	3,772,577	0.723355
23.08	Lung Acquisition [from W/S D-6]	3,757,624	5,119,276	0.734015
23.09				
Outpatient Ancillary Centers				
24.	Clinic	30,062,391	15,280,405	1.967382
25.	Emergency	33,079,278	62,093,247	0.532736
26.	Observation Beds (Non-distinct Part)	297,416	326,754	0.910214
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	202,355,770	235,085	860.78
28.	Psychiatric Unit			See Supplement 1
29.				
30.				
31.	Intensive Care Unit	18,973,996	9,526	1,991.81
32.	Coronary Care Unit	5,458,748	4,506	1,211.44
33.	Surgical ICU	11,355,447	7,588	1,496.50
34.	Neuro ICU	7,886,828	6,082	1,296.75
35.	Cardiothoracic ICU	10,411,057	7,237	1,438.59
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,768,890	6,912	255.92

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

PRELIMINARY

Medicare Provider Number: 26-0032	Public Aid Provider Number: 19014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,717		8,717
Newborn Days	213		213
Total Inpatient Revenue	44,660,473	(412)	44,660,061
Ancillary Revenue	35,251,636	(412)	35,251,224
Routine Revenue	9,408,837		9,408,837
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.
- Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.
- Included \$364 Psychiatric routine charges with Adults & Peds routine charges.
- Removed \$412 OB/Gyn In-vitro charges which are non-covered for Illinois Medicaid.