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: Swedish Covenant Hospital	**Medicare Provider Number:** 14-0114
Street: 5145 N. California Avenue	**Public Aid Provider Number:** 3056
City: Chicago **State:** Illinois	**Zip:** 60625
Period Covered by Statement: **From:** 10-01-04	**To:** 09-30-05

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
XXXX XXXX	Church		Individual		State		Township
	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 Psychiatric		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)) Swedish Covenant Hospital 3056 for the cost report beginning 10-01-04 and ending 09-30-05 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)	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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	199	72,465		62,895	86.79%		13,691	4.95	
2.	Rehabilitation Unit	25	9,125		6,109	66.95%		531	11.50	
3.	Psychiatric Unit	36	13,140		7,697	58.58%		913	8.43	
4.										
5.	Intensive Care Unit	18	6,570		4,869	74.11%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	25	9,125		5,115	56.05%				
16.	Total	303	110,425		86,685	78.50%		15,135	5.39	
17.	Observation Bed Days				2,559					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit									
3.	Psychiatric Unit				2,403			358	6.71	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	**Total**				2,403	2.77%		358	6.71	

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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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 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 & Recovery Room	0.317905						
2.								
3.	Delivery and Labor Room	0.409574						
4.	Anesthesiology	0.068485						
5.	Radiology - Diagnostic	0.207429	14,776			3,065		
6.								
7.								
8.	Laboratory	0.103934	390,098			40,544		
9.	Blood							
10.	Blood - Administration	0.199155	29,005			5,776		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.099821	15,677			1,565		
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.063945	75,272			4,813		
17.	EEG							
18.	Med. / Surg. Supplies	0.073789	29,859			2,203		
19.	Drugs Charged to Patients	0.166450	297,636			49,542		
20.	Renal Dialysis	0.220769						
21.	Ambulance							
22.	CT Scans and MRI	0.086234	59,279			5,112		
23.	Cancer Treatment Center	0.396496						
23.01	Ultrasound	0.203221	4,594			934		
23.02	Special Procedures	0.518564						
23.03	Pathology	0.241504	2,102			508		
23.04	Rehab Medicine, PT, OT and Spee	0.325321	797,268			259,368		
23.05	Cardiac Catheterization Lab	0.166081						
23.06	ASC (Non-distinct Part)	0.205497						
23.07	Family Practice Clinic	1.057320						
23.08	Wound Care	0.340169						
23.09	Pain Management	1.004441						
	Outpatient Service Cost Centers							
24.	Clinic							
25.	Emergency	0.362774						
26.	Observation Beds (Non-distinct Par	0.306378						
27.	**Total**		1,715,566			373,430		

* 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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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)	$ 643.28	$ 431.20	$ 486.17	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			2,403	
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$	$ 1,168,267	$
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)	$	$	$ 1,168,267	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 1,358.04		$
9.	Coronary Care Unit	$		$
10.		$		$
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 309.05		$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 373,430
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **1,541,697**

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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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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.	Rehabilitation Unit						
4.	Psychiatric Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.							
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)**										

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

PRELIMINARY

Medicare Provider Number: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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 & Recovery Room									
2.										
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.										
7.										
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	130	24,105,865	0.000005	15,677					
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	178,108	7,861,930	0.022654	75,272			1,705		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	CT Scans and MRI									
23.	Cancer Treatment Center	14,400	4,888,074	0.002946						
23.01	Ultrasound									
23.02	Special Procedures									
23.03	Pathology									
23.04	Rehab Medicine, PT, OT and Speech									
23.05	Cardiac Catheterization Lab	27,000	28,793,461	0.000938						
23.06	ASC (Non-distinct Part)									
23.07	Family Practice Clinic	446,729	2,307,574	0.193592						
23.08	Wound Care									
23.09	Pain Management									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	3,252,638	27,441,506	0.118530						
26.	Observation Beds (Non-distinct Part)									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	1,171,249	65,454	17.89						
28.	Rehabilitation Unit									
29.	Psychiatric Unit									
30.										
31.	Intensive Care Unit	698,779	4,869	143.52						
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	414,645	5,115	81.06						
37.	**Total**							1,705		

* 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:
14-0114	3056
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 10-01-04 To: 09-30-05

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)	1,541,697		
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)	1,705		
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)**	1,543,402		
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)	1,715,566
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	
	C. Psychiatric Unit	3,484,350
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G.	
	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)**	5,199,916
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	3,656,514
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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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)	1,543,402		
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)	1,543,402		
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)**	1,543,402		

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: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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)	3,656,514
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: 14-0114	**Public Aid Provider Number:** 3056
Program: Medicaid-Psychiatric	**Period Covered by Statement:** From: 10-01-04 To: 09-30-05

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

Medicare Provider Number: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

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 & Recovery Room	21,821,542	68,641,768	0.317905
2.				
3.	Delivery and Labor Room	3,468,123	8,467,635	0.409574
4.	Anesthesiology	1,724,598	25,182,282	0.068485
5.	Radiology - Diagnostic	7,723,237	37,233,104	0.207429
6.				
7.				
8.	Laboratory	9,549,695	91,881,885	0.103934
9.	Blood			
10.	Blood - Administration	2,287,470	11,485,897	0.199155
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,406,278	24,105,865	0.099821
13.	Physical Therapy			
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	502,732	7,861,930	0.063945
17.	EEG			
18.	Med. / Surg. Supplies	4,580,184	62,071,576	0.073789
19.	Drugs Charged to Patients	10,699,807	64,282,406	0.166450
20.	Renal Dialysis	883,556	4,002,182	0.220769
21.	Ambulance			
22.	CT Scans and MRI	4,969,438	57,627,049	0.086234
23.	Cancer Treatment Center	1,938,103	4,888,074	0.396496
23.01	Ultrasound	2,319,859	11,415,470	0.203221
23.02	Special Procedures	1,550,724	2,990,417	0.518564
23.03	Pathology	1,570,138	6,501,512	0.241504
23.04	Rehab Medicine, PT, OT and SpeechT	8,442,181	25,950,302	0.325321
23.05	Cardiac Catheterization Lab	4,782,050	28,793,461	0.166081
23.06	ASC (Non-distinct Part)	1,702,739	8,285,959	0.205497
23.07	Family Practice Clinic	2,439,845	2,307,574	1.057320
23.08	Wound Care	1,671,750	4,914,466	0.340169
23.09	Pain Management	1,581,125	1,574,134	1.004441
	Outpatient Ancillary Centers			
24.	Clinic			
25.	Emergency	9,955,078	27,441,506	0.362774
26.	Observation Beds (Non-distinct Part)	1,561,476	5,096,568	0.306378
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	42,105,493	65,454	643.28
28.	Rehabilitation Unit	2,634,224	6,109	431.20
29.	Psychiatric Unit	3,742,046	7,697	486.17
30.				
31.	Intensive Care Unit	6,612,317	4,869	1,358.04
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,580,786	5,115	309.05

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0114	Public Aid Provider Number: 3056
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-04 To: 09-30-05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,403		2,403
Newborn Days			
Total Inpatient Revenue	5,199,916		5,199,916
Ancillary Revenue	1,715,566		1,715,566
Routine Revenue	3,484,350		3,484,350
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:

Professional Components for Respiratory therapy, Cardiac Cath Lab, and Emergency were included to match W/S A-8-2.