

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: University of Illinois Medical Center at Chicago		Medicare Provider Number: 14-0150
Street: 1740 W. Taylor Street		Public Aid Provider Number: 3098
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 07-01-04	To: 06-30-05

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I <input checked="" type="checkbox"/> Psychiatric	<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)) University of Illinois Medical C 3098 for the cost report beginning 07-01-04 and ending 06-30-05 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)
 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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	290	104,518		69,420	66.42%		18,646	5.33	
2.	Psychiatric Unit	45	15,792		13,418	84.97%		978	13.72	
3.	Rehabilitation Unit	16	5,776		4,186	72.47%		330	12.68	
4.										
5.	Intensive Care Unit	22	7,942		6,578	82.83%				
6.	Coronary Care Unit	19	6,859		5,424	79.08%				
7.	Pediatric ICU	8	4,380		4,380	100.00%				
8.	Neonatal ICU	53	19,228		13,646	70.97%				
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	24	8,760		4,237	48.37%				
16.	Total	477	173,255		121,289	70.01%		19,954	5.87	
17.	Observation Bed Days				2,630					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				8,446			564	14.98	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Pediatric ICU									
8.	Neonatal ICU									
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				8,446	6.96%		564	14.98	

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:	14-0150	Public Aid Provider Number:	3098
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 07-01-04 To: 06-30-05

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	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	0.356541	11,378			4,057		
2.	Recovery Room	0.361990	33,227			12,028		
3.	Delivery and Labor Room	0.759599	46,781			35,535		
4.	Anesthesiology	0.188358	74,858			14,100		
5.	Radiology - Diagnostic	0.260691	260,060			67,795		
6.	Radiology-Therapeutic	0.528037	66,133			34,921		
7.	Kidney Acquisition	0.407882						
8.	Laboratory	0.271775	523,437			142,257		
9.	Liver Transplant/Acquisition	0.580393						
10.	Blood - Administration	0.437091	18,626			8,141		
11.	Radioisotope	0.453933						
12.	Respiratory Therapy	0.163218	65,727			10,728		
13.	Physical Therapy	0.514282	8,642			4,444		
14.	Occupational Therapy	0.678357	866			587		
15.	Speech Pathology	0.539506	1,308			706		
16.	EKG	0.186631	142,464			26,588		
17.	EEG							
18.	Med. / Surg. Supplies	0.536176	252,107			135,174		
19.	Drugs Charged to Patients	0.280836	1,236,643			347,294		
20.	Renal Dialysis	0.426529	60,096			25,633		
21.	Ambulance							
22.								
23.	Neuro Psych Clinic	1.139796	2,610			2,975		
23.01								
23.02								
23.03	Pancreas Acquisition	1.142253						
23.04	Heart Cath Lab	0.400468	30,450			12,194		
23.05	Prosthetics	1.111181						
23.06	Other Organ Transplant	1.782023						
23.07	Eye Clinic	0.894255						
23.08	Primary Care Clinic	0.441386	1,039			459		
23.09	Child/Peds & Adolescent Center	0.664664	1,875			1,246		
Outpatient Service Cost Centers								
24.	Clinic	0.854687	385,960			329,875		
25.	Emergency	0.421832	417,298			176,030		
26.	Observation Beds (Non-distinct Par	0.540519						
27.	Total		3,641,585			1,392,767		

* 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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 894.25	\$ 634.24	\$ 655.34	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		8,446		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 5,356,791	\$	\$
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)	\$	\$ 5,356,791	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,795.25		\$
9.	Coronary Care Unit	\$ 2,340.38		\$
10.	Pediatric ICU	\$ 1,730.28		\$
11.	Neonatal ICU	\$ 1,284.23		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 416.49		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,392,767
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 6,749,558

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

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Pediatric ICU						
9.	Neonatal 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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology-Therapeutic									
7.	Kidney Acquisition									
8.	Laboratory									
9.	Liver Transplant/Acquisition									
10.	Blood - Administration									
11.	Radioisotope									
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.										
23.	Neuro Psych Clinic									
23.01										
23.02										
23.03	Pancreas Acquisition									
23.04	Heart Cath Lab									
23.05	Prosthetics									
23.06	Other Organ Transplant									
23.07	Eye Clinic									
23.08	Primary Care Clinic									
23.09	Child/Peds & Adolescent Center									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Pediatric ICU									
34.	Neonatal ICU									
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total									

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)	6,749,558		
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)	6,749,558		
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)	3,641,585
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	6,124,860
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Pediatric ICU	
	H. Neonatal 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)	9,766,445
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	3,016,887
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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)	6,749,558		
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)	6,749,558		
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)	6,749,558		

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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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)	3,016,887
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: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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 Psychiatric Unit	Sub II Rehabilitation Ur	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

Part C. Program Cost

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

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Ur	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To OHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to OHF Page 4, Line 1)				

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

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	38,290,724	107,395,020	0.356541
2.	Recovery Room	1,918,276	5,299,258	0.361990
3.	Delivery and Labor Room	11,111,396	14,627,968	0.759599
4.	Anesthesiology	5,478,144	29,083,626	0.188358
5.	Radiology - Diagnostic	26,738,710	102,568,646	0.260691
6.	Radiology-Therapeutic	17,183,142	32,541,543	0.528037
7.	Kidney Acquisition	3,920,065	9,610,772	0.407882
8.	Laboratory	34,560,854	127,167,204	0.271775
9.	Liver Transplant/Acquisition	2,648,006	4,562,435	0.580393
10.	Blood - Administration	9,940,107	22,741,489	0.437091
11.	Radioisotope	2,131,125	4,694,804	0.453933
12.	Respiratory Therapy	5,603,859	34,333,548	0.163218
13.	Physical Therapy	2,975,205	5,785,157	0.514282
14.	Occupational Therapy	1,678,356	2,474,148	0.678357
15.	Speech Pathology	1,186,612	2,199,443	0.539506
16.	EKG	1,644,762	8,812,924	0.186631
17.	EEG			
18.	Med. / Surg. Supplies	16,787,054	31,308,872	0.536176
19.	Drugs Charged to Patients	37,584,808	133,831,815	0.280836
20.	Renal Dialysis	8,426,439	19,755,833	0.426529
21.	Ambulance			
22.				
23.	Neuro Psych Clinic	7,052,133	6,187,189	1.139796
23.01				
23.02				
23.03	Pancreas Acquisition	860,248	753,115	1.142253
23.04	Heart Cath Lab	15,394,267	38,440,703	0.400468
23.05	Prosthetics	1,360,212	1,224,114	1.111181
23.06	Other Organ Transplant	1,010,553	567,082	1.782023
23.07	Eye Clinic	10,578,334	11,829,218	0.894255
23.08	Primary Care Clinic	4,957,699	11,232,121	0.441386
23.09	Child/Peds & Adolescent Center	7,541,009	11,345,601	0.664664
Outpatient Ancillary Centers				
24.	Clinic	30,222,621	35,361,044	0.854687
25.	Emergency	11,991,875	28,428,070	0.421832
26.	Observation Beds (Non-distinct Part)	2,232,081	4,129,516	0.540519
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	64,431,016	72,050	894.25
28.	Psychiatric Unit	8,510,193	13,418	634.24
29.	Rehabilitation Unit	2,743,245	4,186	655.34
30.				
31.	Intensive Care Unit	11,809,159	6,578	1,795.25
32.	Coronary Care Unit	12,694,222	5,424	2,340.38
33.	Pediatric ICU	7,578,618	4,380	1,730.28
34.	Neonatal ICU	17,524,540	13,646	1,284.23
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,764,656	4,237	416.49

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

PRELIMINARY

Medicare Provider Number: 14-0150	Public Aid Provider Number: 3098
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07-01-04 To: 06-30-05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,446		8,446
Newborn Days			
Total Inpatient Revenue	9,766,444	1	9,766,445
Ancillary Revenue	3,641,584	1	3,641,585
Routine Revenue	6,124,860		6,124,860
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:

Liver Transplant costs match Liver Acquisition costs per filed W/S B, Part I, Column 25. Redescribed the Liver Transplant cost center as

Liver Transplant/Acquisition. Kidney Acquisition costs were also taken from the filed W/S B, Part I, Column 25.

Liver Transplant/Acquisition, Kidney Acquisition, and Radiology-Therapeutic charges were taken from the filed OHF Supplement No. 2.

All other OHF Supplement No. 2 charges match the filed W/S C, Column 8 charges.

Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.

Total Cost for Observation beds was adjusted to match W/S C, Col. 5.

Radiology-Diagnostic: Includes Rad. Diag.Line 41), CT Scan 41.03, MRI 41.04,Ultrasound 41.05, Vascular Xray 41.06

Total I/P Days for ICU and PICU were adjusted to match W/S S-3, Col. 6.

Total Dept. Costs for Other Organ Transplant, Observation Beds, and Adults and Peds were adjusted to match W/S B, Pt. 1, Col. 25.