

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: Edward Hospital		Medicare Provider Number: 14-0231	
Street: 801 S. Washington Street		Public Aid Provider Number: 14002	
City: Naperville	State: Illinois	Zip: 60566-7060	
Period Covered by Statement:	From: 07-01-05	To: 06-30-06	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<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)) Edward Hospital 14002 for the cost report beginning 07-01-05 and ending 06-30-06 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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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	211	77,015		72,804	94.53%		21,865	3.68	
2.										
3.										
4.										
5.	Intensive Care Unit	15	5,475		3,941	71.98%				
6.	Coronary Care Unit	10	3,650		3,649	99.97%				
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	45	16,425		13,878	84.49%				
16.	Total	281	102,565		94,272	91.91%		21,865	3.68	
17.	Observation Bed Days				4,286					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				3,082			1,065	3.38	
2.										
3.										
4.										
5.	Intensive Care Unit				406					
6.	Coronary Care Unit				117					
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				991					
16.	Total				4,596	4.88%		1,065	3.38	

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:	14-0231	Public Aid Provider Number:	14002
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-05 To: 06-30-06

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	0.346218	1,543,181			534,277		
2.	Recovery Room	0.159228	205,534			32,727		
3.	Delivery and Labor Room	0.468083	317,703			148,711		
4.	Anesthesiology	0.116975	388,150			45,404		
5.	Radiology - Diagnostic	0.406337	338,174			137,413		
6.	Cancer Center	0.311085						
7.	Nuclear Medicine	0.293490	123,126			36,136		
8.	Laboratory	0.135910	2,336,464			317,549		
9.	Blood							
10.	Blood - Administration	0.286880	304,261			87,286		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.230116	1,227,835			282,544		
13.	Physical Therapy	0.359231	132,503			47,599		
14.	Occupational Therapy							
15.	Speech Pathology	0.555444	40,917			22,727		
16.	EKG	0.191817	588,488			112,882		
17.	EEG	0.121837	91,756			11,179		
18.	Med. / Surg. Supplies	0.119202	1,494,635			178,163		
19.	Drugs Charged to Patients	0.156683	3,422,594			536,262		
20.	Renal Dialysis	0.384015						
21.	Ambulance							
22.	Same Day Surgery	1.128449	76,091			85,865		
23.	Gastroenterology [GI]	0.176428	181,834			32,081		
23.01	Ultrasound	0.140218	255,064			35,765		
23.02	CT Scan	0.046767	868,567			40,620		
23.03	MRI	0.106537	342,488			36,488		
23.04	Radiology Oncology	0.295519	27,369			8,088		
23.05	Special Procedures	0.225335	299,425			67,471		
23.06	Imaging Center	0.093503						
23.07	P.E.T.	0.323085						
23.08	Enterostomal Therapy	0.434257	8,046			3,494		
23.09	Cardiac Cath Lab	0.306187	1,578,027			483,171		
Outpatient Service Cost Centers								
24.	Clinic	2.959460						
25.	Emergency	0.252934	2,390,052			604,525		
26.	EMG/NCV	0.059276	11,069			656		
27.	Total		18,593,353			3,929,083		

* 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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 944.95	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	3,082			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 2,912,336	\$	\$	\$
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)	\$ 2,912,336	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,858.10	406	\$ 754,389
9.	Coronary Care Unit	\$ 1,664.93	117	\$ 194,797
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 616.04	991	\$ 610,496
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 3,929,083
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 8,401,101

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

Medicare Provider Number: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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.							
4.							
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 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.	EMG/NCV										
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:	14-0231	Public Aid Provider Number:	14002
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-05 To: 06-30-06

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.	Cancer Center	965,291	46,771,302	0.020639						
7.	Nuclear Medicine									
8.	Laboratory	445,637	102,111,540	0.004364	2,336,464			10,196		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	120,568	24,190,396	0.004984	1,227,835			6,120		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	1,901,760	30,901,372	0.061543	588,488			36,217		
17.	EEG	1,662,200	7,176,017	0.231633	91,756			21,254		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Same Day Surgery									
23.	Gastroenterology [GI]									
23.01	Ultrasound									
23.02	CT Scan									
23.03	MRI									
23.04	Radiology Oncology									
23.05	Special Procedures									
23.06	Imaging Center									
23.07	P.E.T.									
23.08	Enterostomal Therapy									
23.09	Cardiac Cath Lab									
Outpatient Ancillary Cost Centers										
24.	Clinic	30,083	1,358,003	0.022152						
25.	Emergency	7,210,835	86,420,271	0.083439	2,390,052			199,424		
26.	EMG/NCV	260,769	2,586,244	0.100829	11,069			1,116		
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	609,314	77,090	7.90	3,082			24,348		
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	Total							298,675		

* 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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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)	8,401,101		
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)	298,675		
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)	8,699,776		
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)	18,593,353
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	4,573,485
	B.	
	C.	
	D.	
	E. Intensive Care Unit	1,148,922
	F. Coronary Care Unit	408,331
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	1,422,128
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	26,146,219
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	17,446,443
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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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)	8,699,776		
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)	8,699,776		
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)	8,699,776		

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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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)	17,446,443
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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	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	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	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)				
(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, 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: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

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	37,952,074	109,619,027	0.346218
2.	Recovery Room	2,084,682	13,092,423	0.159228
3.	Delivery and Labor Room	5,434,235	11,609,544	0.468083
4.	Anesthesiology	2,413,155	20,629,600	0.116975
5.	Radiology - Diagnostic	12,694,085	31,240,282	0.406337
6.	Cancer Center	14,549,870	46,771,302	0.311085
7.	Nuclear Medicine	2,217,039	7,554,045	0.293490
8.	Laboratory	13,877,937	102,111,540	0.135910
9.	Blood			
10.	Blood - Administration	3,066,443	10,688,923	0.286880
11.	Intravenous Therapy			
12.	Respiratory Therapy	5,566,597	24,190,396	0.230116
13.	Physical Therapy	3,529,348	9,824,737	0.359231
14.	Occupational Therapy			
15.	Speech Pathology	833,453	1,500,516	0.555444
16.	EKG	5,927,408	30,901,372	0.191817
17.	EEG	874,301	7,176,017	0.121837
18.	Med. / Surg. Supplies	4,600,372	38,593,095	0.119202
19.	Drugs Charged to Patients	13,168,714	84,046,737	0.156683
20.	Renal Dialysis	687,421	1,790,091	0.384015
21.	Ambulance			
22.	Same Day Surgery	8,170,823	7,240,755	1.128449
23.	Gastroenterology [GI]	4,069,337	23,065,129	0.176428
23.01	Ultrasound	2,513,152	17,923,233	0.140218
23.02	CT Scan	2,654,956	56,770,428	0.046767
23.03	MRI	2,055,724	19,295,808	0.106537
23.04	Radiology Oncology	5,316,831	17,991,530	0.295519
23.05	Special Procedures	2,656,475	11,789,013	0.225335
23.06	Imaging Center	2,080,378	22,249,358	0.093503
23.07	P.E.T.	866,726	2,682,658	0.323085
23.08	Enterostomal Therapy	157,554	362,813	0.434257
23.09	Cardiac Cath Lab	19,817,544	64,723,578	0.306187
Outpatient Ancillary Centers				
24.	Clinic	4,018,956	1,358,003	2.959460
25.	Emergency	21,858,637	86,420,271	0.252934
26.	EMG/NCV	153,301	2,586,244	0.059276
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	72,846,303	77,090	944.95
28.				
29.				
30.				
31.	Intensive Care Unit	7,322,791	3,941	1,858.10
32.	Coronary Care Unit	6,075,329	3,649	1,664.93
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	8,549,385	13,878	616.04

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

PRELIMINARY

Medicare Provider Number: 14-0231	Public Aid Provider Number: 14002
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-05 To: 06-30-06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,605		3,605
Newborn Days	991		991
Total Inpatient Revenue	26,154,274	(8,055)	26,146,219
Ancillary Revenue	18,601,408	(8,055)	18,593,353
Routine Revenue	7,552,866		7,552,866
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:

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

Figures in filed report for Radioisotope are actually for Cardiac Rehab. Removed \$8,055 in Cardiac Rehab charges.

Cardiac Rehab is not allowed in Illinois Medicaid.

Figures in filed report for Radiology-Therapeutic are actually for EMG/NCV.

Figures in filed report for Blood Administration are actually for Cardiac Cath Lab.

Figures in filed report for Intravenous Therapy are actually for Cancer Center.

Verified by Diane Rodriguez, Strategic Reimbursement on 12/20/2006.