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: Saint Francis Medical Center	Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Avenue	Public Aid Provider Number: 16007
City: Peoria / State: Illinois	Zip: 61637
Period Covered by Statement: From: 10/01/05	To: 09/30/06

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)

XXXX XXXX	Medicaid Hospital		Medicaid Sub II		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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/05 and ending 09/30/06 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)	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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	374	136,510		103,167	75.57%		22,266	5.28	
2.	Rehabilitation Unit	24	8,760		6,673	76.18%		552	12.09	
3.										
4.										
5.	Intensive Care Unit	45	16,425		14,327	87.23%				
6.	Coronary Care Unit									
7.	Premature ICU									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total	443	161,695		124,167	76.79%		22,818	5.44	
17.	Observation Bed Days				6,642					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			3,254	15,830			2,968	6.07	
2.	Rehabilitation Unit									
3.										
4.										
5.	Intensive Care Unit				2,195					
6.	Coronary Care Unit									
7.	Premature ICU									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	**Total**			3,254	18,025	14.52%		2,968	6.07	

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)**			

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

PRELIMINARY

Medicare Provider Number: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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 Total Billed O/P Charges (Gross) for Health Care Program Patients	Referred O/P E/R Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	Referred O/P E/R O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.349354	9,811,983			3,427,856		
2.	Recovery Room	0.255061	802,107			204,586		
3.	Delivery and Labor Room	0.729275	2,768,269			2,018,829		
4.	Anesthesiology	0.088910	2,198,962			195,510		
5.	Radiology - Diagnostic	0.189916	10,760,589			2,043,608		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.094244	9,873,720			930,539		
9.	Blood							
10.	Blood - Administration	0.498701	799,503			398,713		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.113813	6,547,275			745,165		
13.	Physical Therapy	0.484058	584,366			282,867		
14.	Occupational Therapy							
15.	Speech Pathology	0.447574	92,108			41,225		
16.	EKG	0.117834	285,908			33,690		
17.	EEG	0.519099	308,641			160,215		
18.	Med. / Surg. Supplies	0.106961	4,884,546			522,456		
19.	Drugs Charged to Patients	0.247390	11,559,178			2,859,625		
20.	Renal Dialysis	0.463811	549,007			254,635		
21.	Ambulance Services	0.379928	2,250,138			854,890		
22.	Digestive Diseases	0.108037	623,639			67,376		
23.	Rehab Services							
23.01	Cardiac Catheter Lab	0.213182	2,627,652			560,168		
23.02	Special Clinics	0.787708	1,216			958		
23.03	Psychology	0.872680						
23.04								
23.05	Diabetes Service	1.617168	15,571			25,181		
23.06	Urological	0.359645	8,011			2,881		
23.07	Kidney Acquisition(W/S D-6)	1.123964	189,780			213,306		
23.08	Sister's Clinic	1.872182	1,045			1,956		
23.09	Sleep Disorders	0.275371	146			40		
	Outpatient Service Cost Centers							
24.	Clinic							
25.	Emergency	0.381132	1,706,477			650,393		
26.	Observation Beds (Non-distinct Par	1.130431	77,912			88,074		
27.	**Total**		69,327,749			16,584,742		

* 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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 859.25	$ 703.67	$	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	15,830			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 13,601,928	$	$	$
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)	3,254			
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)	$ 13,601,928	$	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,490.83	2,195	$ 3,272,372
9.	Coronary Care Unit	$		$
10.	Premature ICU	$		$
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$		$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 16,584,742
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **33,459,042**

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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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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.	Rehabilitation Unit						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Premature ICU						
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
		(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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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	1,692,450	345,874,953	0.004893	10,760,589			52,652		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	22,318	69,754,443	0.000320	6,547,275			2,095		
13.	Physical Therapy	524,872	21,313,116	0.024627	584,366			14,391		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance Services	6,217	17,449,697	0.000356	2,250,138			801		
22.	Digestive Diseases									
23.	Rehab Services									
23.01	Cardiac Catheter Lab									
23.02	Special Clinics	174,708	607,978	0.287359	1,216			349		
23.03	Psychology									
23.04										
23.05	Diabetes Service									
23.06	Urological									
23.07	Kidney Acquisition(W/S D-6)									
23.08	Sister's Clinic	1,657	2,583,477	0.000641	1,045			1		
23.09	Sleep Disorders	544,309	8,274,082	0.065785	146			10		
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	2,521,626	65,201,531	0.038674	1,706,477			65,996		
26.	Observation Beds (Non-distinct Part)									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	510,313	109,809	4.65	15,830			73,610		
28.	Rehabilitation Unit									
29.										
30.										
31.	Intensive Care Unit	186,774	14,327	13.04	2,195			28,623		
32.	Coronary Care Unit									
33.	Premature ICU									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	**Total**							238,528		

* 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:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/05 To: 09/30/06

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)	33,459,042		
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)	238,528		
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)**	33,697,570		
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)	69,327,749
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	8,982,549
	B. Rehabilitation Unit	
	C.	
	D.	
	E. Intensive Care Unit	1,233,149
	F. Coronary Care Unit	
	G. Premature ICU	
	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)**	79,543,447
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	45,845,877
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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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)	33,697,570		
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)	33,697,570		
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)**	33,697,570		

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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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)	45,845,877
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: 14-0067	**Public Aid Provider Number:** 16007
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 10/01/05 To: 09/30/06

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 Rehabilitation Ur**	**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 Rehabilitation Ur**	**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 Rehabilitation Ur**	**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 25,31,31.01, 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: 14-0067	Public Aid Provider Number: 16007
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/05 To: 09/30/06

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	64,929,733	185,856,342	0.349354
2.	Recovery Room	2,792,627	10,948,856	0.255061
3.	Delivery and Labor Room	5,947,989	8,156,030	0.729275
4.	Anesthesiology	3,355,852	37,744,379	0.088910
5.	Radiology - Diagnostic	65,687,204	345,874,953	0.189916
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	29,669,537	314,814,757	0.094244
9.	Blood			
10.	Blood - Administration	4,205,697	8,433,301	0.498701
11.	Intravenous Therapy			
12.	Respiratory Therapy	7,938,941	69,754,443	0.113813
13.	Physical Therapy	10,316,774	21,313,116	0.484058
14.	Occupational Therapy			
15.	Speech Pathology	1,012,158	2,261,434	0.447574
16.	EKG	2,593,886	22,013,039	0.117834
17.	EEG	1,118,970	2,155,600	0.519099
18.	Med. / Surg. Supplies	5,683,738	53,138,610	0.106961
19.	Drugs Charged to Patients	30,106,817	121,697,641	0.247390
20.	Renal Dialysis	2,350,010	5,066,744	0.463811
21.	Ambulance Services	6,629,634	17,449,697	0.379928
22.	Digestive Diseases	4,161,001	38,514,563	0.108037
23.	Rehab Services			
23.01	Cardiac Catheter Lab	20,915,939	98,113,273	0.213182
23.02	Special Clinics	478,909	607,978	0.787708
23.03	Psychology	417,175	478,039	0.872680
23.04				
23.05	Diabetes Service	711,148	439,749	1.617168
23.06	Urological	143,392	398,704	0.359645
23.07	Kidney Acquisition(W/S D-6)	2,148,965	1,911,952	1.123964
23.08	Sister's Clinic	4,836,740	2,583,477	1.872182
23.09	Sleep Disorders	2,278,441	8,274,082	0.275371
	Outpatient Ancillary Centers			
24.	Clinic			
25.	Emergency	24,850,414	65,201,531	0.381132
26.	Observation Beds (Non-distinct Part)	5,592,645	4,947,357	1.130431
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	94,353,724	109,809	859.25
28.	Rehabilitation Unit	4,695,599	6,673	703.67
29.				
30.				
31.	Intensive Care Unit	21,359,095	14,327	1,490.83
32.	Coronary Care Unit			
33.	Premature ICU			
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery			

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/05 To: 09/30/06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	18,025		18,025
Newborn Days			
Total Inpatient Revenue	79,558,910	(15,463)	79,543,447
Ancillary Revenue	69,343,212	(15,463)	69,327,749
Routine Revenue	10,215,698		10,215,698
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.

Filed OHF Supplement No. 2 charges for Radiology-Diagnostic, Physical Therapy, Special Clinics, Sister's Clinic,

Diabetes Clinic, Psychology, Sleep Disorders, Med. Supplies, Operating Room and ER

are greater than the filed W/S C charges.

Adjusted Total Beds, Total Bed Days, and Total I/P Days to match W/S S-3.

Removed $15,463 of charges for Cardio-Pulm Rehab. Cardio-Pulm Rehab is noncovered for Illinois Medicaid.

Adjusted Professional Component for A&P and ICU to match W/S A-8-2.

Adjusted Total Dept. Costs for A&P and ICU to match W/S B, Pt. 1, Col. 25.

Adjusted Total Charges for Lab and Psychology to agree with W/S C.