Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Lincoln Park Hospital	**Medicare Provider Number:** 14-0207
Street: 550 West Webster Street	**Medicaid Provider Number:** 3031
City: Chicago **State:** Illinois	**Zip:** 60414-3787
Period Covered by Statement: **From:** 01/01/06	**To:** 12/31/06

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
[ ]	Church	[ ]	Individual	[ ]	State	[ ]	Township
[ ]	Corporation	[ ]	Partnership	[ ]	City	[ ]	Hospital District
[ ]	Other (Specify)	[XXXX]	Corporation	[ ]	County	[ ]	Other (Specify)

Type of Hospital

[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]	Medicaid Sub II Psychiatric Unit	[ ]	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)) Lincoln Park Hospital 3031 for the cost report beginning 01/01/06 and ending 12/31/06 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):

Name (Typewritten)
Title Date
Firm
Telephone Number

Signed (Officer or Administrator of Provider(s)):

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 Healthcare and Family Services 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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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	133	48,545		16,993	35.00%		4,263	4.69	
2.	Rehabilitation Unit	22	8,030		3,172	39.50%		274	11.58	
3.	Psychiatric Unit	10	3,650		3,017	82.66%		444	6.80	
4.	Sub III									
5.	Intensive Care Unit	12	4,380		3,007	68.65%				
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				692					
16.	Total	177	64,605		26,881	41.61%		4,981	5.26	
17.	Observation Bed Days				580					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit									
3.	Psychiatric Unit				1,483			232	6.39	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	**Total**				1,483	5.52%		232	6.39	

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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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	0.464534						
2.	Recovery Room	0.185992	5,997			1,115		
3.	Delivery and Labor Room	0.630872						
4.	Anesthesiology	0.118456	6,179			732		
5.	Radiology - Diagnostic	0.720522	5,077			3,658		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.267285						
8.	Laboratory	0.233004	209,089			48,719		
9.	Blood							
10.	Blood - Administration	0.129473	62			8		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.132037	2,318			306		
13.	Physical Therapy	0.105101	2,995			315		
14.	Occupational Therapy	0.142561						
15.	Speech Pathology	0.231362						
16.	EKG	0.076849	12,226			940		
17.	EEG	0.680014						
18.	Med. / Surg. Supplies	0.319330	14,434			4,609		
19.	Drugs Charged to Patients	0.244867	287,696			70,447		
20.	Renal Dialysis	0.339909						
21.	Ambulance							
22.	Ultrasound	0.240834						
23.	MRI	0.201381						
23.01	Cat Scan	0.144880	1,481			215		
23.02	Minor Procedures	0.981125						
23.03	Endoscopy	0.077923						
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic							
25.	Emergency	0.142680	24,755			3,532		
26.	Observation	0.668094	588			393		
27.	**Total**		572,897			134,989		

* 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:	Medicaid Provider Number:
14-0207	3031
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/06 To: 12/31/06

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Psychiatric Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 619.28	$ 630.57	$ 366.50	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,483	
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$	$ 543,520	$
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 (BHF 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)	$	$	$ 543,520	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 936.75		$
9.	Coronary Care Unit	$		$
10.	Other	$		$
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 629.52		$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 134,989
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **678,509**

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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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF 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.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
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										
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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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	342,210	8,016,749	0.042687						
2.	Recovery Room									
3.	Delivery and Labor Room	929,493	3,060,536	0.303703						
4.	Anesthesiology	9,930	4,999,071	0.001986	6,179			12		
5.	Radiology - Diagnostic	72,000	3,634,081	0.019812	5,077			101		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	60,000	10,297,721	0.005827	12,226			71		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	MRI									
23.01	Cat Scan									
23.02	Minor Procedures									
23.03	Endoscopy									
23.04	Other									
23.05	Other									
23.06	Other									
23.07	Other									
23.08	Other									
23.09	Other									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	313,000	13,706,794	0.022835	24,755			565		
26.	Observation									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Psychiatric Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	**Total**							749		

* 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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	678,509		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)	749		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)**	679,258		
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)	572,897
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	
	C. Psychiatric Unit	1,577,367
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	2,150,264
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,471,006
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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	679,258		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	679,258		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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)**	679,258		

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: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 (BHF Page 7, Line 12)	1,471,006
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 (BHF 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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0207	**Medicaid Provider Number:** 3031
Program: Medicaid-Psychiatric	**Period Covered by Statement:** From: 01/01/06 To: 12/31/06

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

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

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Rehabilitation Ur**	**Sub II Psychiatric Unit**	**Sub III 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 BHF 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 BHF Page 4, Line 1)**				

Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0207	Medicaid Provider Number: 3031
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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 BHF pgs. 3-4)
	Inpatient Ancillary Centers			
1.	Operating Room	3,724,049	8,016,749	0.464534
2.	Recovery Room	346,996	1,865,647	0.185992
3.	Delivery and Labor Room	1,930,805	3,060,536	0.630872
4.	Anesthesiology	592,172	4,999,071	0.118456
5.	Radiology - Diagnostic	2,618,435	3,634,081	0.720522
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	388,470	1,453,392	0.267285
8.	Laboratory	2,313,207	9,927,745	0.233004
9.	Blood			
10.	Blood - Administration	603,745	4,663,103	0.129473
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,036,243	7,848,134	0.132037
13.	Physical Therapy	905,261	8,613,222	0.105101
14.	Occupational Therapy	357,380	2,506,861	0.142561
15.	Speech Pathology	115,897	500,933	0.231362
16.	EKG	791,372	10,297,721	0.076849
17.	EEG	63,667	93,626	0.680014
18.	Med. / Surg. Supplies	2,813,569	8,810,854	0.319330
19.	Drugs Charged to Patients	3,810,407	15,561,104	0.244867
20.	Renal Dialysis	427,204	1,256,820	0.339909
21.	Ambulance			
22.	Ultrasound	407,309	1,691,243	0.240834
23.	MRI	354,144	1,758,573	0.201381
23.01	Cat Scan	634,980	4,382,802	0.144880
23.02	Minor Procedures	565,869	576,755	0.981125
23.03	Endoscopy	279,774	3,590,368	0.077923
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic			
25.	Emergency	1,955,686	13,706,794	0.142680
26.	Observation	360,023	538,881	0.668094
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	10,882,663	17,573	619.28
28.	Rehabilitation Unit	2,000,179	3,172	630.57
29.	Psychiatric Unit	1,105,741	3,017	366.50
30.	Sub III			
31.	Intensive Care Unit	2,816,811	3,007	936.75
32.	Coronary Care Unit			
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	435,630	692	629.52

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0207	3031
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/06 To: 12/31/06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,483		1,483
Newborn Days			
Total Inpatient Revenue	2,434,849	(284,585)	2,150,264
Ancillary Revenue	857,482	(284,585)	572,897
Routine Revenue	1,577,367		1,577,367
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:

BHF Supplement 2 charges match the Medicare W/S C charges.

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

Removed $284,585 Partial Hospitalization charges which are non-covered for Illinois Medicaid.