

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: Condell Medical Center		Medicare Provider Number: 14-0202	
Street: 801 S. Milwaukee Avenue on Condell Drive		Public Aid Provider Number: 12010	
City: Libertyville	State: Illinois	Zip: 60048	
Period Covered by Statement:	From: 01-01-07	To: 12-31-07	

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)) Condell Medical Center 12010 for the cost report beginning 01-01-07 and ending 12-31-07 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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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	228	83,220		64,482	77.48%		17,960	3.88	
2.										
3.										
4.										
5.	Intensive Care Unit	25	9,125		5,286	57.93%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	26	9,490		7,054	74.33%				
16.	Total	279	101,835		76,822	75.44%		17,960	3.88	
17.	Observation Bed Days				2,290					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				10,198			2,585	4.15	
2.										
3.										
4.										
5.	Intensive Care Unit				542					
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				3,249					
16.	Total				13,989	18.21%		2,585	4.15	

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:	14-0202	Public Aid Provider Number:	12010
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-07 To: 12-31-07

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	0.279007	1,597,773			445,790		
2.	Recovery Room	0.193772	521,917			101,133		
3.	Delivery and Labor Room	0.191996	2,757,799			529,486		
4.	Anesthesiology	0.306608	597,366			183,157		
5.	Radiology - Diagnostic	0.316378	1,013,101			320,523		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.188765	446,304			84,247		
8.	Laboratory	0.110661	6,228,279			689,228		
9.	Blood							
10.	Blood - Administration	0.289366	1,065,566			308,339		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.139622	4,409,016			615,596		
13.	Physical Therapy	0.488483	242,938			118,671		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.178602	245,619			43,868		
17.	EEG	0.379561	48,800			18,523		
18.	Med. / Surg. Supplies	0.085192	4,301,543			366,457		
19.	Drugs Charged to Patients	0.144365	10,448,441			1,508,389		
20.	Renal Dialysis	0.337576	117,212			39,568		
21.	Ambulance							
22.	Ultrasound	0.250711	291,551			73,095		
23.	Electromyography(EMG)	0.159584	29,087			4,642		
23.01	Stress Test	0.412236	37,452			15,439		
23.02	Echocardiogram	0.083016	583,413			48,433		
23.03	Cardiology	0.639069	6,013			3,843		
23.04	Cardiac Cath Lab	0.283461	1,021,249			289,484		
23.05	Outpatient Surgery	1.592624						
23.06	MRI	0.061936	694,903			43,040		
23.07	Reference Lab	1.395933						
23.08	CT Scan	0.040961	1,947,803			79,784		
23.09	Radiology Special Procedures	0.161793	6,938			1,123		
Outpatient Service Cost Centers								
24.	Clinic	0.251816	16,139			4,064		
25.	Emergency	0.352206	2,251,520			792,999		
26.	Observation Beds (Non-distinct Par	0.278247						
27.	Total		40,927,742			6,728,921		

* 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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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)	\$ 972.57	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	10,198			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 9,918,269	\$	\$	\$
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)	\$ 9,918,269	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,130.45	542	\$ 1,154,704
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 516.14	3,249	\$ 1,676,939
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 6,728,921
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 19,478,833

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

Medicare Provider Number: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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.	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:	14-0202	Public Aid Provider Number:	12010
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-07 To: 12-31-07

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	314,033	31,231,486	0.010055	1,013,101			10,187		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	72,230	41,415,385	0.001744	4,409,016			7,689		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	295,258	7,513,199	0.039299	245,619			9,653		
17.	EEG	338,520	3,677,352	0.092055	48,800			4,492		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Electromyography(EMG)									
23.01	Stress Test									
23.02	Echocardiogram	778,159	12,591,216	0.061802	583,413			36,056		
23.03	Cardiology	121,607	1,312,519	0.092652	6,013			557		
23.04	Cardiac Cath Lab	6,572	43,612,742	0.000151	1,021,249			154		
23.05	Outpatient Surgery									
23.06	MRI									
23.07	Reference Lab									
23.08	CT Scan	200,000	57,403,374	0.003484	1,947,803			6,786		
23.09	Radiology Special Procedures									
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	50,000	66,772	0.75	10,198			7,649		
28.										
29.										
30.										
31.	Intensive Care Unit	1,106,500	5,286	209.33	542			113,457		
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	200,000	7,054	28.35	3,249			92,109		
37.	Total							288,789		

* 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: 14-0202		Public Aid Provider Number: 12010		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-07 To: 12-31-07		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	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)	19,478,833		
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)	288,789		
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)	19,767,622		
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)	40,927,742
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	22,193,919
	B.	
	C.	
	D.	
	E. Intensive Care Unit	2,006,242
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	5,936,011
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	71,063,914
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	51,296,292
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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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)	19,767,622		
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)	19,767,622		
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)	19,767,622		

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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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)	51,296,292
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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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	41,166,421	147,546,091	0.279007
2.	Recovery Room	3,123,518	16,119,555	0.193772
3.	Delivery and Labor Room	4,384,590	22,836,937	0.191996
4.	Anesthesiology	4,286,579	13,980,655	0.306608
5.	Radiology - Diagnostic	9,880,965	31,231,486	0.316378
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	4,468,407	23,671,781	0.188765
8.	Laboratory	13,957,713	126,130,392	0.110661
9.	Blood			
10.	Blood - Administration	2,963,822	10,242,467	0.289366
11.	Intravenous Therapy			
12.	Respiratory Therapy	5,782,513	41,415,385	0.139622
13.	Physical Therapy	10,054,064	20,582,216	0.488483
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	1,341,869	7,513,199	0.178602
17.	EEG	1,395,778	3,677,352	0.379561
18.	Med. / Surg. Supplies	3,375,318	39,620,265	0.085192
19.	Drugs Charged to Patients	16,121,062	111,669,050	0.144365
20.	Renal Dialysis	1,066,577	3,159,513	0.337576
21.	Ambulance			
22.	Ultrasound	2,916,214	11,631,794	0.250711
23.	Electromyography(EMG)	117,660	737,290	0.159584
23.01	Stress Test	1,140,838	2,767,440	0.412236
23.02	Echocardiogram	1,045,277	12,591,216	0.083016
23.03	Cardiology	838,790	1,312,519	0.639069
23.04	Cardiac Cath Lab	12,362,503	43,612,742	0.283461
23.05	Outpatient Surgery	295,873	185,777	1.592624
23.06	MRI	1,216,635	19,643,507	0.061936
23.07	Reference Lab	622,959	446,267	1.395933
23.08	CT Scan	2,351,292	57,403,374	0.040961
23.09	Radiology Special Procedures	1,678,099	10,371,916	0.161793
Outpatient Ancillary Centers				
24.	Clinic	1,340,051	5,321,555	0.251816
25.	Emergency	14,540,466	41,284,004	0.352206
26.	Observation Beds (Non-distinct Part)	2,227,185	8,004,341	0.278247
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	64,940,137	66,772	972.57
28.				
29.				
30.				
31.	Intensive Care Unit	11,261,576	5,286	2,130.45
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	3,640,863	7,054	516.14

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

PRELIMINARY

Medicare Provider Number: 14-0202	Public Aid Provider Number: 12010
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,641	3,099	10,740
Newborn Days	3,555	(306)	3,249
Total Inpatient Revenue	71,063,914		71,063,914
Ancillary Revenue	40,927,742		40,927,742
Routine Revenue	30,136,172		30,136,172
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:

- Filed OHF Supplement No. 2 charges match the filed W/S C.
- Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.
- Adjusted Adults & Peds Beds Available (228) and Total Inpatient Days (64,482) to match W/S S-3.
- Adjusted Medicaid days to agree with W/S S-3. Submitted Medicaid days were the same as in prior year.
- Medicaid days on W/S S-3, Column 5 were confirmed by Dan Maruz, Consultant-----DW 07/14/2008.
- Adjusted Costs for all Cost Centers on OHF Supplement No. 2 to agree with W/S B Part I, Column 25, per instructions.