

# 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: Children's Hospital of Illinois		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Avenue		Public Aid Provider Number: 16008
City: Peoria	State: Illinois	Zip: 61637
Period Covered by Statement:	From: 10-01-02	To: 09-30-03

## Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input 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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) Children's Hospital

## 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)) Children's Hospital of Illinois 16008 for the cost report beginning 10-01-02 and ending 09-30-03 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: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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	65	23,725		12,135	51.15%		3,219	7.81	
2.										
3.										
4.										
5.	Intensive Care Unit	12	4,380		3,699	84.45%				
6.	Coronary Care Unit									
7.	Premature Intensive Care	35	12,775		9,298	72.78%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total	112	40,880		25,132	61.48%		3,219	7.81	
17.	Observation Bed Days				722					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				6,138			1,582	8.29	
2.										
3.										
4.										
5.	Intensive Care Unit				2,621					
6.	Coronary Care Unit									
7.	Premature Intensive Care				4,358					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				13,117	52.19%		1,582	8.29	

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:	14-0067	Public Aid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10-01-02 To: 09-30-03

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	0.388249	1,714,687			665,726		
2.	Recovery Room	0.281541	185,252			52,156		
3.	Delivery and Labor Room	0.796977	5,569			4,438		
4.	Anesthesiology	0.085736	997,850			85,552		
5.	Radiology - Diagnostic	0.247350	2,146,907			531,037		
6.	Neurodiagnostic Center	0.748134						
7.	Eating Disorders Clinic	1.336335						
8.	Laboratory	0.145007	5,295,088			767,825		
9.	Urological	0.389358						
10.	Blood - Administration	0.588850	199,892			117,706		
11.	Lithotripsy	0.336737						
12.	Respiratory Therapy	0.153934	5,058,036			778,604		
13.	Sleeping Disorders	0.375967						
14.	Pain Program	1.041787						
15.	Speech Pathology & Audiology	0.544538	86,848			47,292		
16.	EKG	0.148090	527,715			78,149		
17.	EEG	0.825825	108,297			89,434		
18.	Med. / Surg. Supplies	0.068443	8,893,944			608,728		
19.	Drugs Charged to Patients	0.305325	5,838,115			1,782,522		
20.	Renal Dialysis	0.560912	7,326			4,109		
21.	Ambulance Services	0.548208	1,164,033			638,132		
22.	PBP Clinical Lab Services Pgm	0.006524						
23.	Digestive Diseases	0.153688	13,762			2,115		
23.01	Enterostomal	1.012285						
23.02	Rehabilitation Services	0.580836	138,970			80,719		
23.03	Cardiac Catheter Lab	0.312492	226,539			70,792		
23.04	Krasse Health Center	7.115872						
23.05	Special Clinics	0.828572	1,453			1,204		
23.06	Sisters Clinic	6.764921						
23.07	Diabetes Service	2.922815						
23.08	Center for Senior Health	3.260380						
23.09	Psychology	1.355771	3,734			5,062		
<b>Outpatient Service Cost Centers</b>								
24.	Comp Epilepsy	14.415117						
25.	Emergency	0.493512	32,246			15,914		
26.	Observation Beds (Non-distinct Par	1.128781						
27.	<b>Total</b>		32,646,263			6,427,216		

\* 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: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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)	\$ 742.32	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	6,138			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 4,556,360	\$	\$	\$
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)	\$ 4,556,360	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,392.58	2,621	\$ 3,649,952
9.	Coronary Care Unit	\$		\$
10.	Premature Intensive Care	\$ 1,046.54	4,358	\$ 4,560,821
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)			\$ 6,427,216
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 19,194,349</b>

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

<b>Medicare Provider Number:</b> 14-0067	<b>Public Aid Provider Number:</b> 16008
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

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.	Premature Intensive Care						
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.	Comp Epilepsy										
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:	14-0067	Public Aid Provider Number:	16008
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 10-01-02 To: 09-30-03

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	124,800	138,158,930	0.000903	1,714,687			1,548		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic	1,302,305	184,915,356	0.007043	2,146,907			15,121		
6.	Neurodiagnostic Center	165,271	447,460	0.369354						
7.	Eating Disorders Clinic									
8.	Laboratory									
9.	Urological									
10.	Blood - Administration									
11.	Lithotripsy									
12.	Respiratory Therapy									
13.	Sleeping Disorders									
14.	Pain Program									
15.	Speech Pathology & Audiology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance Services									
22.	PBP Clinical Lab Services Pgm									
23.	Digestive Diseases									
23.01	Enterostomal									
23.02	Rehabilitation Services	485,161	15,096,818	0.032137	138,970			4,466		
23.03	Cardiac Catheter Lab									
23.04	Krasse Health Center									
23.05	Special Clinics	127,917	433,979	0.294754	1,453			428		
23.06	Sisters Clinic									
23.07	Diabetes Service									
23.08	Center for Senior Health									
23.09	Psychology	5,011	334,805	0.014967	3,734			56		
Outpatient Ancillary Cost Centers										
24.	Comp Epilepsy									
25.	Emergency	2,243,711	46,312,934	0.048447	32,246			1,562		
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	747,244	12,857	58.12	6,138			356,741		
28.										
29.										
30.										
31.	Intensive Care Unit	147,031	3,699	39.75	2,621			104,185		
32.	Coronary Care Unit									
33.	Premature Intensive Care									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							484,107		

\* 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: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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)	19,194,349		
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)	484,107		
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	19,678,456		
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)	32,646,263
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,988,578
	B.	
	C.	
	D.	
	E. Intensive Care Unit	1,276,184
	F. Coronary Care Unit	
	G. Premature Intensive Care	2,121,907
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	39,032,932
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	19,354,476
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: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

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)	19,678,456		
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)	19,678,456		
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	19,678,456		

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

Medicare Provider Number: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges**

<b>Line No.</b>	(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)	19,354,476
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.	<b>Total (Sum of Lines 1 - 3)</b>							

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

OHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

**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, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to OHF Page 4, Line 1)				

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

OHF Supplement No. 2

**PRELIMINARY**

<b>Medicare Provider Number:</b> 14-0067	<b>Public Aid Provider Number:</b> 16008
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 10-01-02 To: 09-30-03

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	53,640,006	138,158,930	0.388249
2.	Recovery Room	2,245,699	7,976,462	0.281541
3.	Delivery and Labor Room	4,660,342	5,847,525	0.796977
4.	Anesthesiology	2,605,705	30,392,202	0.085736
5.	Radiology - Diagnostic	45,738,813	184,915,356	0.247350
6.	Neurodiagnostic Center	334,760	447,460	0.748134
7.	Eating Disorders Clinic	308,720	231,020	1.336335
8.	Laboratory	27,437,619	189,216,243	0.145007
9.	Urological	141,444	363,275	0.389358
10.	Blood - Administration	3,867,952	6,568,649	0.588850
11.	Lithotripsy	476,623	1,415,415	0.336737
12.	Respiratory Therapy	6,612,598	42,957,429	0.153934
13.	Sleeping Disorders	1,893,866	5,037,322	0.375967
14.	Pain Program	1,158,466	1,111,999	1.041787
15.	Speech Pathology & Audiology	868,260	1,594,490	0.544538
16.	EKG	1,943,915	13,126,588	0.148090
17.	EEG	848,689	1,027,686	0.825825
18.	Med. / Surg. Supplies	3,801,636	55,544,179	0.068443
19.	Drugs Charged to Patients	23,128,518	75,750,375	0.305325
20.	Renal Dialysis	1,849,178	3,296,736	0.560912
21.	Ambulance Services	5,855,419	10,681,019	0.548208
22.	PBP Clinical Lab Services Pgm	139,927	21,446,899	0.006524
23.	Digestive Diseases	3,485,520	22,679,240	0.153688
23.01	Enterostomal	195,204	192,835	1.012285
23.02	Rehabilitation Services	8,768,775	15,096,818	0.580836
23.03	Cardiac Catheter Lab	16,928,920	54,173,863	0.312492
23.04	Krasse Health Center	1,933,240	271,680	7.115872
23.05	Special Clinics	359,583	433,979	0.828572
23.06	Sisters Clinic	4,437,944	656,023	6.764921
23.07	Diabetes Service	679,195	232,377	2.922815
23.08	Center for Senior Health	553,156	169,660	3.260380
23.09	Psychology	453,919	334,805	1.355771
<b>Outpatient Ancillary Centers</b>				
24.	Comp Epilepsy	434,832	30,165	14.415117
25.	Emergency	22,855,974	46,312,934	0.493512
26.	Observation Beds (Non-distinct Part)	4,369,444	3,870,941	1.128781
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	9,543,985	12,857	742.32
28.				
29.				
30.				
31.	Intensive Care Unit	5,151,157	3,699	1,392.58
32.	Coronary Care Unit			
33.	Premature Intensive Care	9,730,730	9,298	1,046.54
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: 14-0067	Public Aid Provider Number: 16008
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-02 To: 09-30-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	13,117		13,117
Newborn Days			
Total Inpatient Revenue	39,032,932		39,032,932
Ancillary Revenue	32,646,263		32,646,263
Routine Revenue	6,386,669		6,386,669
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, Rehabilitation Services, Special Clinics and ER are greater than the filed W/S C charges.