

# 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: LaGrange Memorial		Medicare Provider Number: 14-0065	
Street: 5101 S. Willow Springs Road		Public Aid Provider Number: 12009	
City: LaGrange	State: Illinois	Zip: 60525	
Period Covered by Statement:	From: 11-01-03	To: 10-31-04	

## 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)) LaGrange Memorial 12009 for the cost report beginning 11-01-03 and ending 10-31-04 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: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

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	143	52,313		39,988	76.44%		9,079	4.53	
2.										
3.										
4.										
5.	Intensive Care Unit	27	9,855		1,097	11.13%				
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				1,485					
16.	Total	170	62,168		42,570	68.48%		9,079	4.53	
17.	Observation Bed Days				1,566					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,715			453	3.90	
2.										
3.										
4.										
5.	Intensive Care Unit				52					
6.	Coronary Care Unit									
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				309					
16.	Total				2,076	4.88%		453	3.90	

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:	14-0065	Public Aid Provider Number:	12009
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 11-01-03 To: 10-31-04

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/ Anesthesia	0.290610	534,825			155,425		
2.	Recovery Room	0.269306	40,130			10,807		
3.	Delivery and Labor Room	0.719501	504,180			362,758		
4.	Anesthesiology							
5.	Radiology - Diagnostic/ Mammogra	0.281354	142,730			40,158		
6.	Radiology - Therapeutic	0.459388	103			47		
7.	Nuclear Medicine	0.162263	94,844			15,390		
8.	Laboratory	0.212082	1,043,379			221,282		
9.	Blood							
10.	Blood Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.156050	464,239			72,444		
13.	Physical Therapy	0.383498	61,187			23,465		
14.	Occupational Therapy	0.360251	22,364			8,057		
15.	Speech Pathology	0.424896	9,686			4,116		
16.	EKG/ Cardiac Cath Lab/ Cath Lab	0.137973	327,790			45,226		
17.	EEG/ EMG	0.171358	17,164			2,941		
18.	Med. / Surg. Supplies	0.377265	206,150			77,773		
19.	Drugs Charged to Patients/ IV Ther	0.221416	1,519,204			336,376		
20.	Renal Dialysis	0.426917	84,474			36,063		
21.	Ambulance							
22.	Endoscopy/ GI Lab	0.240180	63,919			15,352		
23.	Day Surgery/ OP Surgery	0.574578	1,215			698		
23.01	Ultrasound	0.166529	40,956			6,820		
23.02	CT Scan	0.085353	341,133			29,117		
23.03	MRI	0.099709	190,324			18,977		
23.04	Grant Square Imaging	0.287025						
23.05	PET Scan	0.327458	4,394			1,439		
23.06	Vascular Lab/ Vascular Intv	0.197033	116,575			22,969		
23.07	Hemodialysis/ Lithotripsy	0.426917						
23.08	OP Department	1.283738						
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic/ Workright	2.145751	350			751		
25.	Emergency/ ER MedSurg Ovrlw	0.240635	426,111			102,537		
26.	Observation Beds (Non-distinct Par	0.474270						
27.	<b>Total</b>		6,257,426			1,610,988		

\* 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: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

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)	\$ 674.03	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,715			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,155,961	\$	\$	\$
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)	\$ 1,155,961	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 4,367.98	52	\$ 227,135
9.	Coronary Care Unit	\$		\$
10.		\$		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 435.31	309	\$ 134,511
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,610,988
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 3,128,595</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> 14-0065	<b>Public Aid Provider Number:</b> 12009
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 11-01-03 To: 10-31-04

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/ Workright										
14.	Emergency/ ER MedSurg Ovrflw										
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: <b>14-0065</b>	Public Aid Provider Number: <b>12009</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>11-01-03</b> To: <b>10-31-04</b>

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/ Anesthesia									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic/ Mammograp									
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/ Cardiac Cath Lab/ Cath Lab									
17.	EEG/ EMG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients/ IV Thera									
20.	Renal Dialysis									
21.	Ambulance									
22.	Endoscopy/ GI Lab									
23.	Day Surgery/ OP Surgery									
23.01	Ultrasound									
23.02	CT Scan									
23.03	MRI									
23.04	Grant Square Imaging									
23.05	PET Scan									
23.06	Vascular Lab/ Vascular Intv									
23.07	Hemodialysis/ Lithotripsy									
23.08	OP Department									
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic/ Workright									
25.	Emergency/ ER MedSurg Ovrflw									
26.	Observation Beds (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.										
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>									

\* 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**

<b>Medicare Provider Number:</b> 14-0065		<b>Public Aid Provider Number:</b> 12009		
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 11-01-03 To: 10-31-04		
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)	3,128,595		
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)			
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>	3,128,595		
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)	6,257,426
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,475,416
	B.	
	C.	
	D.	
	E. Intensive Care Unit	273,590
	F. Coronary Care Unit	
	G.	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	220,030
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	8,226,462
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	5,097,867
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**

<b>Medicare Provider Number:</b> 14-0065	<b>Public Aid Provider Number:</b> 12009
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 11-01-03 To: 10-31-04

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)	3,128,595		
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)	3,128,595		
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>	3,128,595		

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: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

**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)	5,097,867
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
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: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

**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

Medicare Provider Number: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

**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/ Anesthesia	14,236,854	48,989,572	0.290610
2.	Recovery Room	892,919	3,315,625	0.269306
3.	Delivery and Labor Room	1,892,117	2,629,764	0.719501
4.	Anesthesiology			
5.	Radiology - Diagnostic/ Mammography	4,027,382	14,314,263	0.281354
6.	Radiology - Therapeutic	2,188,140	4,763,167	0.459388
7.	Nuclear Medicine	972,224	5,991,638	0.162263
8.	Laboratory	8,217,843	38,748,354	0.212082
9.	Blood			
10.	Blood Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,055,317	13,170,904	0.156050
13.	Physical Therapy	3,948,362	10,295,640	0.383498
14.	Occupational Therapy	301,382	836,588	0.360251
15.	Speech Pathology	213,205	501,782	0.424896
16.	EKG/ Cardiac Cath Lab/ Cath Lab	3,243,195	23,506,042	0.137973
17.	EEG/ EMG	304,318	1,775,921	0.171358
18.	Med. / Surg. Supplies	2,850,684	7,556,189	0.377265
19.	Drugs Charged to Patients/ IV Therapy	8,612,047	38,895,284	0.221416
20.	Renal Dialysis	758,374	1,776,398	0.426917
21.	Ambulance			
22.	Endoscopy/ GI Lab	1,658,271	6,904,270	0.240180
23.	Day Surgery/ OP Surgery	2,005,838	3,490,977	0.574578
23.01	Ultrasound	567,765	3,409,399	0.166529
23.02	CT Scan	2,124,856	24,894,890	0.085353
23.03	MRI	1,219,160	12,227,202	0.099709
23.04	Grant Square Imaging	1,123,265	3,913,473	0.287025
23.05	PET Scan	310,247	947,441	0.327458
23.06	Vascular Lab/ Vascular Intv	1,909,379	9,690,647	0.197033
23.07	Hemodialysis/ Lithotripsy	758,374	1,776,398	0.426917
23.08	OP Department	504,961	393,352	1.283738
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic/ Workright	428,852	199,861	2.145751
25.	Emergency/ ER MedSurg Ovrflw	5,343,886	22,207,445	0.240635
26.	Observation Beds (Non-distinct Part)	939,522	1,980,985	0.474270
<b>Routine Service Cost Centers</b>				
27.	Adults and Pediatrics	28,008,613	41,554	674.03
28.				
29.				
30.				
31.	Intensive Care Unit	4,791,673	1,097	4,367.98
32.	Coronary Care Unit			
33.				
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	646,431	1,485	435.31

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

PRELIMINARY

Medicare Provider Number: 14-0065	Public Aid Provider Number: 12009
Program: Medicaid-Hospital	Period Covered by Statement: From: 11-01-03 To: 10-31-04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,767		1,767
Newborn Days	309		309
Total Inpatient Revenue	8,421,249	(194,787)	8,226,462
Ancillary Revenue	6,452,213	(194,787)	6,257,426
Routine Revenue	1,969,036		1,969,036
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
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 charges.

Disallowed \$194,787 Cardiac Rehab- charges as noncovered for Illinois Medicaid.