

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: Loyola University Medical Center d/b/a Foster G. McGaw Hospital		Medicare Provider Number: 14-0276
Street: 2160 South First Avenue		Public Aid Provider Number: 13027
City: Maywood	State: Illinois	Zip: 60153
Period Covered by Statement:	From: 07/01/03	To: 06/30/04

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"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Rehabilitation	<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)) Loyola University Medical Cen 13027 for the cost report beginning 07/01/03 and ending 06/30/04 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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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	263	96,258		67,242	69.86%		21,366	4.65	
2.	Rehabilitation Unit	24	8,784		8,174	93.06%		715	11.43	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	51	18,666		17,469	93.59%				
6.	Coronary Care Unit	8	2,928		2,393	81.73%				
7.	Burn ICU	18	6,588		5,873	89.15%				
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU	9	3,294		3,275	99.42%				
11.	Bone ICU	13	4,758		3,148	66.16%				
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	25	9,150		3,304	36.11%				
16.	Total	411	150,426		110,878	73.71%		22,081	4.87	
17.	Observation Bed Days				2,428					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit				391			49	7.98	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Burn ICU									
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU									
11.	Bone ICU									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				391	0.35%		49	7.98	

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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room/ ASC	0.456582	210			96		
2.	Recovery Room	0.147311						
3.	Delivery and Labor Room	0.408009						
4.	Anesthesiology	0.214609	245			53		
5.	Radiology-Diagnostic,Ultrasound,M	0.290600	34,288			9,964		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.376427						
8.	Laboratory-Surg Path,Neurosurg,H	0.223278	102,665			22,923		
9.	Blood							
10.	Blood - Administration	0.532263	1,370			729		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.231714	37,847			8,770		
13.	Physical Therapy	0.360597	173,415			62,533		
14.	Occupational Therapy	0.407532	129,604			52,818		
15.	Speech Pathology	0.783390	58,430			45,773		
16.	EKG	0.281812	400			113		
17.	EEG	0.491865	670			330		
18.	Med. / Surg. Supplies	0.301654	47,647			14,373		
19.	Drugs Charged to Patients	0.290421	147,916			42,958		
20.	Renal Dialysis	0.514997	11,567			5,957		
21.	Ambulance	0.928746	1,800			1,672		
22.	Cancer Center	0.564555						
23.	Loyola OP Center/Psychosocial Re	0.977959	32,808			32,085		
23.01	Cardiac Cath, Biopsy/Right, Hear F	0.271226						
23.02	Gastro Services	0.214486	2,663			571		
23.03	Pulmonary Labs	0.471483						
23.04	Hyperalimentation	0.747077	4,305			3,216		
23.05	Peripheral Vascular	0.282938	3,578			1,012		
23.06	Occ. Health, Bone Marrow,Clinic	0.979415						
23.07								
23.08	Other							
23.09	Organ Acquisition (from W/S D-6)	0.880839						
Outpatient Service Cost Centers								
24.	Clinic/PCCs/Lines 60.10-60.21							
25.	Emergency	0.457746						
26.	Observation	0.640362						
27.	Total		791,428			305,946		

* 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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 844.48	\$ 1,030.98	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		391		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 403,113	\$	\$
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)	\$	\$ 403,113	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,239.84		\$
9.	Coronary Care Unit	\$ 1,349.87		\$
10.	Burn ICU	\$ 1,046.19		\$
11.	Neonatal ICU	\$		\$
12.	Pediatric ICU	\$		\$
13.	Heart Transplant ICU	\$ 1,292.26		\$
14.	Bone ICU	\$ 1,395.94		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 393.56		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 305,946
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 709,059

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

Medicare Provider Number: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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.	Rehabilitation Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	Neonatal ICU						
10.	Pediatric ICU						
10.01	Heart Transplant ICU						
10.02	Bone ICU						
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
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic/PCCs/Lines 60.10-60.21										
14.	Emergency										
15.	Observation										
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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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/ ASC									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology-Diagnostic,Ultrasound,MR									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory-Surg Path,Neurosurg,HL									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Cancer Center									
23.	Loyola OP Center/Psychosocial Reh									
23.01	Cardiac Cath, Biopsy/Right, Hear Fa									
23.02	Gastro Services									
23.03	Pulmonary Labs									
23.04	Hyperalimentation									
23.05	Peripheral Vascular									
23.06	Occ. Health, Bone Marrow,Clinic									
23.07										
23.08	Other									
23.09	Organ Acquisition (from W/S D-6)									
Outpatient Ancillary Cost Centers										
24.	Clinic/PCCs/Lines 60.10-60.21									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Burn ICU									
34.	Neonatal ICU									
35.	Pediatric ICU									
35.01	Heart Transplant ICU									
35.02	Bone ICU									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total									

* 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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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)	709,059		
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.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	709,059		
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)	791,428
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	544,478
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Burn ICU	
	H. Neonatal ICU	
	I. Pediatric ICU	
	J. Heart Transplant ICU	
	K. Bone ICU	
	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)	1,335,906
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	626,847
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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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)	709,059		
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)	709,059		
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)	709,059		

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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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)	626,847
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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Rehabilitation Ur	Sub II Sub II	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 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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

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)
Inpatient Ancillary Centers				
1.	Operating Room/ ASC	62,369,177	136,600,060	0.456582
2.	Recovery Room	3,346,833	22,719,501	0.147311
3.	Delivery and Labor Room	4,693,319	11,502,978	0.408009
4.	Anesthesiology	10,588,462	49,338,285	0.214609
5.	Radiology-Diagnostic,Ultrasound,MRI,CT Scan	33,036,385	113,683,530	0.290600
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	5,418,882	14,395,578	0.376427
8.	Laboratory-Surg Path,Neurosurg,HLA	33,448,229	149,805,420	0.223278
9.	Blood			
10.	Blood - Administration	8,290,269	15,575,522	0.532263
11.	Intravenous Therapy			
12.	Respiratory Therapy	9,668,622	41,726,580	0.231714
13.	Physical Therapy	4,552,228	12,624,153	0.360597
14.	Occupational Therapy	1,987,572	4,877,091	0.407532
15.	Speech Pathology	1,947,646	2,486,176	0.783390
16.	EKG	16,839,661	59,755,025	0.281812
17.	EEG	2,108,153	4,286,043	0.491865
18.	Med. / Surg. Supplies	8,639,438	28,640,238	0.301654
19.	Drugs Charged to Patients	28,054,660	96,599,976	0.290421
20.	Renal Dialysis	6,479,843	12,582,285	0.514997
21.	Ambulance	4,205,526	4,528,175	0.928746
22.	Cancer Center	30,066,170	53,256,428	0.564555
23.	Loyola OP Center/Psychosocial Rehab	45,713,690	46,743,952	0.977959
23.01	Cardiac Cath, Biopsy/Right, Hear Failure	13,692,879	50,485,214	0.271226
23.02	Gastro Services	4,422,148	20,617,403	0.214486
23.03	Pulmonary Labs	997,220	2,115,069	0.471483
23.04	Hyperalimentation	1,424,954	1,907,372	0.747077
23.05	Peripheral Vascular	1,159,996	4,099,818	0.282938
23.06	Occ. Health, Bone Marrow,Clinic	2,889,461	2,950,191	0.979415
23.07				
23.08	Other			
23.09	Organ Acquisition (from W/S D-6)	8,109,024	9,206,020	0.880839
Outpatient Ancillary Centers				
24.	Clinic/PCCs/Lines 60.10-60.21			
25.	Emergency	17,876,941	39,054,255	0.457746
26.	Observation	2,030,159	3,170,329	0.640362
Routine Service Cost Centers				
27.	Adults and Pediatrics	58,834,957	69,670	844.48
28.	Rehabilitation Unit	8,427,260	8,174	1,030.98
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	21,658,851	17,469	1,239.84
32.	Coronary Care Unit	3,230,238	2,393	1,349.87
33.	Burn ICU	6,144,251	5,873	1,046.19
34.	Neonatal ICU			
35.	Pediatric ICU			
35.01	Heart Transplant ICU	4,232,143	3,275	1,292.26
35.02	Bone ICU	4,394,417	3,148	1,395.94
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,300,316	3,304	393.56

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

Preliminary

Medicare Provider Number: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/03 To: 06/30/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	391		391
Newborn Days			
Total Inpatient Revenue	1,435,906	(100,000)	1,335,906
Ancillary Revenue	791,428		791,428
Routine Revenue	644,478	(100,000)	544,478
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:

This subprovider is listed as Sub-II on Medicare report. No Sub-I is listed.

Psych subprovider was eliminated a few years ago.