

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: 07/01/04	To: 06/30/05

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 07/01/04 and ending 06/30/05 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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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	270	98,679		70,357	71.30%		22,348	4.54	
2.	Rehabilitation Unit	24	8,760		7,851	89.62%		655	11.99	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	55	20,075		16,251	80.95%				
6.	Coronary Care Unit	8	2,920		2,589	88.66%				
7.	Burn ICU	18	6,570		5,487	83.52%				
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU	9	3,285		3,506	106.73%				
11.	Bone ICU	13	4,745		3,292	69.38%				
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	25	9,125		3,529	38.67%				
16.	Total	422	154,159		112,862	73.21%		23,003	4.75	
17.	Observation Bed Days				2,860					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit				657			56	11.73	
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				657	0.58%		56	11.73	

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-Rehab	Period Covered by Statement:	From: 07/01/04 To: 06/30/05

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/ ASC	0.459251	16,027			7,360		
2.	Recovery Room	0.162346	9,070			1,472		
3.	Delivery and Labor Room	0.428253						
4.	Anesthesiology	0.225627	14,288			3,224		
5.	Radiology-Diagnostic,Ultrasound,M	0.293647	84,944			24,944		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.345088	3,859			1,332		
8.	Laboratory-Surg Path,Neurosurg,H	0.212794	126,609			26,942		
9.	Blood							
10.	Blood - Administration	0.532621	13,061			6,957		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.259132	24,831			6,435		
13.	Physical Therapy	0.422219	142,186			60,034		
14.	Occupational Therapy	0.412711	122,260			50,458		
15.	Speech Pathology	0.711640	1,497			1,065		
16.	EKG	0.285260	4,769			1,360		
17.	EEG	0.489508	320			157		
18.	Med. / Surg. Supplies	0.390381	60,871			23,763		
19.	Drugs Charged to Patients	0.251102	200,283			50,291		
20.	Renal Dialysis	0.445362	4,230			1,884		
21.	Ambulance	1.027254	5,100			5,239		
22.	Cancer Center	0.576196						
23.	Loyola OP Center/Psychosocial Re	0.919716	25,806			23,734		
23.01	Cardiac Cath, Biopsy/Right, Heart F	0.269698	55,669			15,014		
23.02	Gastro Services	0.239854	4,951			1,188		
23.03	Pulmonary Labs	0.489712						
23.04	Hyperalimentation	0.731688	8,013			5,863		
23.05	Peripheral Vascular	0.311122	3,480			1,083		
23.06	Occ. Health, Bone Marrow,Clinic	0.863960						
23.07	OBT Medical Center	0.572605						
23.08								
23.09	Organ Acquisition (from W/S D-6)	0.754192						
Outpatient Service Cost Centers								
24.	Clinic/PCCs/Lines 60.10-60.21	1.118448						
25.	Emergency	0.333760	1,420			474		
26.	Observation	0.701538						
27.	Total		933,544			320,273		

* 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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	\$ 896.20	\$ 848.01	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		657		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 557,143	\$	\$
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)	\$	\$ 557,143	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,454.67		\$
9.	Coronary Care Unit	\$ 1,404.76		\$
10.	Burn ICU	\$ 1,228.64		\$
11.	Neonatal ICU	\$		\$
12.	Pediatric ICU	\$		\$
13.	Heart Transplant ICU	\$ 1,314.02		\$
14.	Bone ICU	\$ 1,417.78		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 436.19		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 320,273
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 877,416

**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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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, Heart 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	OBT Medical Center									
23.08										
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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	877,416		
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)	877,416		
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)	933,544
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	599,011
	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)	1,532,555
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	655,139
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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	877,416		
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)	877,416		
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)	877,416		

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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	655,139
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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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	68,381,635	148,898,172	0.459251
2.	Recovery Room	3,922,006	24,158,353	0.162346
3.	Delivery and Labor Room	4,966,507	11,597,121	0.428253
4.	Anesthesiology	12,371,097	54,829,755	0.225627
5.	Radiology-Diagnostic,Ultrasound,MRI,CT Scan	35,545,004	121,046,852	0.293647
6.	Radiology - Therapeutic	937,581		
7.	Nuclear Medicine	5,637,183	16,335,493	0.345088
8.	Laboratory-Surg Path,Neurosurg,HLA	33,810,936	158,890,368	0.212794
9.	Blood			
10.	Blood - Administration	8,408,739	15,787,461	0.532621
11.	Intravenous Therapy			
12.	Respiratory Therapy	10,062,890	38,833,097	0.259132
13.	Physical Therapy	5,339,949	12,647,333	0.422219
14.	Occupational Therapy	2,240,454	5,428,631	0.412711
15.	Speech Pathology	1,754,637	2,465,626	0.711640
16.	EKG	19,336,077	67,783,989	0.285260
17.	EEG	2,331,383	4,762,707	0.489508
18.	Med. / Surg. Supplies	8,765,829	22,454,561	0.390381
19.	Drugs Charged to Patients	24,369,486	97,050,165	0.251102
20.	Renal Dialysis	8,517,158	19,124,136	0.445362
21.	Ambulance	4,581,406	4,459,857	1.027254
22.	Cancer Center	32,657,006	56,676,934	0.576196
23.	Loyola OP Center/Psychosocial Rehab	54,035,527	58,752,408	0.919716
23.01	Cardiac Cath, Biopsy/Right, Heart Failure	13,861,999	51,398,211	0.269698
23.02	Gastro Services	4,363,193	18,191,002	0.239854
23.03	Pulmonary Labs	1,109,632	2,265,886	0.489712
23.04	Hyperalimentation	1,657,727	2,265,621	0.731688
23.05	Peripheral Vascular	1,514,785	4,868,780	0.311122
23.06	Occ. Health, Bone Marrow,Clinic	2,817,969	3,261,688	0.863960
23.07	OBT Medical Center	9,900,039	17,289,480	0.572605
23.08				
23.09	Organ Acquisition (from W/S D-6)	5,835,825	7,737,855	0.754192
Outpatient Ancillary Centers				
24.	Clinic/PCCs/Lines 60.10-60.21	26,427,220	23,628,474	1.118448
25.	Emergency	14,030,052	42,036,378	0.333760
26.	Observation	2,591,539	3,694,080	0.701538
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	65,617,405	73,217	896.20
28.	Rehabilitation Unit	6,657,704	7,851	848.01
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	23,639,794	16,251	1,454.67
32.	Coronary Care Unit	3,636,916	2,589	1,404.76
33.	Burn ICU	6,741,530	5,487	1,228.64
34.	Neonatal ICU			
35.	Pediatric ICU			
35.01	Heart Transplant ICU	4,606,940	3,506	1,314.02
35.02	Bone ICU	4,667,329	3,292	1,417.78
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,539,331	3,529	436.19

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

Preliminary

Medicare Provider Number: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	657		657
Newborn Days			
Total Inpatient Revenue	1,532,555		1,532,555
Ancillary Revenue	933,544		933,544
Routine Revenue	599,011		599,011
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 is listed on Medicare Report as Sub-Provider II. Psych Unit closed several years ago.

Routine charges have been bundled to include reported Routine charges in Acute Care, ICU, CCU, and Burn ICU.

Operating Room costs and charges also include data from Ambulatory Surgery Center.

Cardiac Rehab data removed as it is non-covered for Illinois Medicaid.

Changed name of Cost Center from "All Other OP Clinics" (23.06) to "Occ. Health,Bone Marrow, Clinic"