

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

**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 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)) Loyola University Medical Cen 13027 for the cost report beginning 07/01/05 and ending 06/30/06 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-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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	279	101,776		69,000	67.80%		21,637	4.59	
2.	Rehabilitation Unit	24	8,760		8,386	95.73%		662	12.67	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	56	20,315		16,176	79.63%				
6.	Coronary Care Unit	7	2,680		2,243	83.69%				
7.	Burn ICU	16	5,899		5,280	89.51%				
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU	9	3,285		3,465	105.48%				
11.	Bone ICU	13	4,745		3,109	65.52%				
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	25	9,125		3,373	36.96%				
16.	Total	429	156,585		111,032	70.91%		22,299	4.83	
17.	Observation Bed Days				2,658					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				9,238			3,104	4.36	
2.	Rehabilitation Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				1,831					
6.	Coronary Care Unit				213					
7.	Burn ICU				1,231					
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU				427					
11.	Bone ICU				605					
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				814					
16.	Total				14,359	12.93%		3,104	4.36	

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

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	0.455368	6,888,167			3,136,651		
2.	Recovery Room	0.153432	1,207,193			185,222		
3.	Delivery and Labor Room	0.396536	4,273,262			1,694,502		
4.	Anesthesiology	0.174421	3,401,747			593,336		
5.	Radiology-Diagnostic,Ultrasound,M	0.285424	6,112,510			1,744,657		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.324789	280,887			91,229		
8.	Laboratory-Surg Path, HLA	0.183852	9,156,089			1,683,365		
9.	Blood							
10.	Blood - Administration	0.426922	2,086,746			890,878		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.333620	2,472,872			825,000		
13.	Physical Therapy	0.413475	296,396			122,552		
14.	Occupational Therapy	0.376532	228,152			85,907		
15.	Speech Pathology	0.513547	144,509			74,212		
16.	EKG	0.272198	2,362,475			643,061		
17.	EEG	0.458426	235,219			107,831		
18.	Med. / Surg. Supplies	0.685785	1,425,947			977,893		
19.	Drugs Charged to Patients	0.253278	10,835,137			2,744,302		
20.	Renal Dialysis	0.444670	232,972			103,596		
21.	Ambulance	0.998951	120,115			119,989		
22.	Cancer Center	0.545670	31,333			17,097		
23.	Loyola OP Center/Psych social Ref	0.822874	96,915			79,749		
23.01	Cath Lab, Biopsy/Right Cardiac Ca	0.249875	1,958,332			489,338		
23.02	Gastro Services	0.248309	510,682			126,807		
23.03	Pulmonary Labs	0.396372						
23.04	Hyperalimentation	0.736562	228,508			168,310		
23.05	Peripheral Vascular	0.289346	215,081			62,233		
23.06	Occ. Health, Bone Marrow,Clinic	0.723286	192,097			138,941		
23.07	OBT Medical Center	0.508805						
23.08								
23.09	Organ Acquisition (from W/S D-6)	1.050055	478,149			502,083		
<b>Outpatient Service Cost Centers</b>								
24.	Clinic/PCCs/Lines 60.10-60.22	0.869360	1,205			1,048		
25.	Emergency	0.313919	2,236,664			702,131		
26.	Observation (Non-distinct Part)	0.635865						
27.	<b>Total</b>		57,709,361			18,111,920		

\* 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-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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)	\$ 900.05	\$ 768.36	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	9,238			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 8,314,662	\$	\$	\$
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)	\$ 8,314,662	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,472.92	1,831	\$ 2,696,917
9.	Coronary Care Unit	\$ 1,421.74	213	\$ 302,831
10.	Burn ICU	\$ 1,299.96	1,231	\$ 1,600,251
11.	Neonatal ICU	\$		\$
12.	Pediatric ICU	\$		\$
13.	Heart Transplant ICU	\$ 1,349.10	427	\$ 576,066
14.	Bone ICU	\$ 1,445.75	605	\$ 874,679
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 390.44	814	\$ 317,818
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 18,111,920
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 32,795,144</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> 14-0276		<b>Public Aid Provider Number:</b> 13027	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 07/01/05 To: 06/30/06	

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 60.10-60.22										
14.	Emergency										
15.	Observation (Non-distinct Part)										
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-Hospital	Period Covered by Statement:	From: 07/01/05 To: 06/30/06

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, HLA									
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/Psych social Reha									
23.01	Cath Lab, Biopsy/Right Cardiac Cath									
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)									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic/PCCs/Lines 60.10-60.22									
25.	Emergency									
26.	Observation (Non-distinct Part)									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
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.	<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**

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

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)	32,795,144		
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>	32,795,144		
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)	57,709,361
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	9,839,068
	B. Rehabilitation Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	3,924,270
	F. Coronary Care Unit	672,975
	G. Burn ICU	1,939,710
	H. Neonatal ICU	
	I. Pediatric ICU	
	J. Heart Transplant ICU	889,650
	K. Bone ICU	1,425,269
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	3,445,397
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	79,845,700
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	47,050,556
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> 14-0276	<b>Public Aid Provider Number:</b> 13027
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 07/01/05 To: 06/30/06

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)	32,795,144		
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)	32,795,144		
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>	32,795,144		

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

**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)	47,050,556
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: 14-0276	Public Aid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/05 To: 06/30/06

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

**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/ ASC	68,855,835	151,209,270	0.455368
2.	Recovery Room	3,545,902	23,110,537	0.153432
3.	Delivery and Labor Room	4,990,149	12,584,347	0.396536
4.	Anesthesiology	9,474,994	54,322,410	0.174421
5.	Radiology-Diagnostic,Ultrasound,MRI,CT Scan	41,981,311	147,083,816	0.285424
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	6,149,392	18,933,521	0.324789
8.	Laboratory-Surg Path, HLA	31,582,345	171,781,634	0.183852
9.	Blood			
10.	Blood - Administration	8,995,273	21,070,076	0.426922
11.	Intravenous Therapy			
12.	Respiratory Therapy	9,383,491	28,126,307	0.333620
13.	Physical Therapy	5,481,484	13,257,115	0.413475
14.	Occupational Therapy	2,189,578	5,815,118	0.376532
15.	Speech Pathology	801,428	1,560,574	0.513547
16.	EKG	18,297,161	67,220,029	0.272198
17.	EEG	2,375,833	5,182,587	0.458426
18.	Med. / Surg. Supplies	7,675,794	11,192,718	0.685785
19.	Drugs Charged to Patients	24,395,021	96,317,000	0.253278
20.	Renal Dialysis	8,842,168	19,884,770	0.444670
21.	Ambulance	4,297,014	4,301,527	0.998951
22.	Cancer Center	34,740,425	63,665,686	0.545670
23.	Loyola OP Center/Psych social Rehab	52,300,778	63,558,661	0.822874
23.01	Cath Lab, Biopsy/Right Cardiac Cath	12,023,043	48,116,320	0.249875
23.02	Gastro Services	4,437,967	17,872,730	0.248309
23.03	Pulmonary Labs	889,510	2,244,129	0.396372
23.04	Hyperalimentation	1,652,840	2,243,992	0.736562
23.05	Peripheral Vascular	1,439,885	4,976,350	0.289346
23.06	Occ. Health, Bone Marrow,Clinic	1,786,051	2,469,355	0.723286
23.07	OBT Medical Center	10,100,296	19,851,010	0.508805
23.08				
23.09	Organ Acquisition (from W/S D-6)	5,434,827	5,175,755	1.050055
<b>Outpatient Ancillary Centers</b>				
24.	Clinic/PCCs/Lines 60.10-60.22	24,641,631	28,344,575	0.869360
25.	Emergency	14,222,230	45,305,417	0.313919
26.	Observation (Non-distinct Part)	2,505,789	3,940,759	0.635865
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	64,496,061	71,658	900.05
28.	Rehabilitation Unit	6,443,499	8,386	768.36
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	23,825,981	16,176	1,472.92
32.	Coronary Care Unit	3,188,961	2,243	1,421.74
33.	Burn ICU	6,863,768	5,280	1,299.96
34.	Neonatal ICU			
35.	Pediatric ICU			
35.01	Heart Transplant ICU	4,674,620	3,465	1,349.10
35.02	Bone ICU	4,494,822	3,109	1,445.75
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,316,970	3,373	390.44

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

PRELIMINARY

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	13,350	195	13,545
Newborn Days	814		814
Total Inpatient Revenue	79,263,079	582,621	79,845,700
Ancillary Revenue	57,709,361		57,709,361
Routine Revenue	21,553,718	582,621	22,136,339
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:**

- Removed the (316) NICU days and 122 PICU days and respective charges and included with Ronald McDonald Children's Hospital cost report.
- Adjustment made to move \$646,996 Nursery charges from McDonald cost report to Foster McGaw cost report.
- Adjustment made to move 1 Bone ICU day from McDonald cost report to Foster McGaw cost report.
- Cardiac Rehab data removed as it is non-covered for Illinois Medicaid.