

# 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: Rush Children's Hospital		Medicare Provider Number: 14-0119	
Street: 1753 West Congress Parkway		Public Aid Provider Number: 3047	
City: Chicago	State: Illinois	Zip: 60612	
Period Covered by Statement:	From: 07-01-05	To: 06-30-06	

**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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) Children's

**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)) Rush Children's Hospital 3047 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: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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	28	10,220	1,304	3,949	38.64%		27,001	0.91	
2.								1,137		
3.								1,980		
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU									
8.	Medical ICU									
9.	Pediatric ICU	20	7,300		4,212	57.70%				
10.	Perinatal ICU	52	18,980		16,419	86.51%				
11.										
12.										
13.										
14.										
15.	Newborn Nursery	11	4,015		439	10.93%				
16.	Total	111	40,515	1,304	25,019	61.75%		30,118	0.82	
17.	Observation Bed Days				57					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			572	1,759			1,322	10.59	
2.										
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Surgical ICU									
8.	Medical ICU									
9.	Pediatric ICU				2,151					
10.	Perinatal ICU				10,092					
11.										
12.										
13.										
14.										
15.	Newborn Nursery				217					
16.	Total			572	14,219	56.83%		1,322	10.59	

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:	14-0119	Public Aid Provider Number:	3047
Program:	Medicaid-Children's	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	0.290839	3,394,612			987,286		
2.	Recovery Room	0.228557	106,244			24,283		
3.	Delivery and Labor Room	0.370891	366,473			135,922		
4.	Anesthesiology	0.102776	1,028,713			105,727		
5.	Radiology - Diagnostic	0.199225	2,771,309			552,114		
6.	Radiology - Therapeutic	0.252028	62,563			15,768		
7.	Radioisotope	0.183110	46,105			8,442		
8.	Laboratory	0.195138	8,399,917			1,639,143		
9.	Blood							
10.	Blood - Administration	0.277660	2,733,215			758,904		
11.	Intravenous Therapy	0.071720	1,241,663			89,052		
12.	Respiratory Therapy	0.309714	6,338,899			1,963,246		
13.	Physical Therapy	0.285422	251,729			71,849		
14.	Occupational Therapy	0.479537	8,677			4,161		
15.	Speech Pathology	0.628880	62,273			39,162		
16.	EKG	0.214027	1,185,156			253,655		
17.	EEG	0.360108	318,778			114,795		
18.	Med. / Surg. Supplies	0.049864	77,356			3,857		
19.	Drugs Charged to Patients	0.179562	10,473,272			1,880,602		
20.	Renal Dialysis	1.391445						
21.	Renal Dialysis Inpatient	0.275399	29,364			8,087		
22.	Behavioral Health	0.836853	87,947			73,599		
23.	Kidney Acquisition [per W/S D-6]	0.417024	120,000			50,043		
23.01	Liver Acquisition [per W/S D-6]	0.655714						
23.02	Heart Acquisition [per W/S D-6]	4.434248						
23.03	Pancreas Acquisition [per W/S D-6]	1.392899						
23.04	Psych Day Hospital	0.725644						
23.05								
23.06								
23.07								
23.08								
23.09								
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.423546						
25.	Emergency	0.302491	527,391			159,531		
26.	Observation Beds (Non-distinct Par	0.176612						
27.	<b>Total</b>		39,631,656			8,939,228		

\* 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: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 864.58	\$ #VALUE!	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,759			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,520,796	\$	\$	\$
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)	572			
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)	\$ 1,520,796	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$		\$
10.	Surgical ICU	\$		\$
11.	Medical ICU	\$		\$
12.	Pediatric ICU	\$ 1,687.60	2,151	\$ 3,630,028
13.	Perinatal ICU	\$ 1,080.78	10,092	\$ 10,907,232
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 536.56	217	\$ 116,434
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 8,939,228
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 25,113,718</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> 14-0119	<b>Public Aid Provider Number:</b> 3047
<b>Program:</b> Medicaid-Children's	<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.							
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Medical ICU						
10.	Pediatric ICU						
10.01	Perinatal ICU						
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										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: <b>14-0119</b>	Public Aid Provider Number: <b>3047</b>
Program: <b>Medicaid-Children's</b>	Period Covered by Statement: From: <b>07-01-05</b> To: <b>06-30-06</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									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
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.	Renal Dialysis Inpatient									
22.	Behavioral Health									
23.	Kidney Acquisition [per W/S D-6]									
23.01	Liver Acquisition [per W/S D-6]									
23.02	Heart Acquisition [per W/S D-6]									
23.03	Pancreas Acquisition [per W/S D-6]									
23.04	Psych Day Hospital									
23.05										
23.06										
23.07										
23.08										
23.09										
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency									
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.	Surgical ICU									
34.	Medical ICU									
35.	Pediatric ICU									
35.01	Perinatal ICU									
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**

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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)	25,113,718		
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>	25,113,718		
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)	39,631,656
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,963,276
	B.	
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Surgical ICU	
	H. Medical ICU	
	I. Pediatric ICU	6,996,901
	J. Perinatal ICU	28,992,542
	K.	
	L.	
	M.	
	N.	
	O. Nursery	295,448
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	78,879,823
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	53,766,105
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> 14-0119	<b>Public Aid Provider Number:</b> 3047
<b>Program:</b> Medicaid-Children's	<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)	25,113,718		
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)	25,113,718		
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>	25,113,718		

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: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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)	53,766,105
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: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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	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: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	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	98,167,164	337,530,791	0.290839
2.	Recovery Room	3,535,826	15,470,202	0.228557
3.	Delivery and Labor Room	7,828,489	21,107,236	0.370891
4.	Anesthesiology	7,623,943	74,180,158	0.102776
5.	Radiology - Diagnostic	37,220,925	186,828,484	0.199225
6.	Radiology - Therapeutic	7,676,947	30,460,698	0.252028
7.	Radioisotope	4,069,046	22,221,906	0.183110
8.	Laboratory	69,349,598	355,387,785	0.195138
9.	Blood			
10.	Blood - Administration	15,008,870	54,054,821	0.277660
11.	Intravenous Therapy	2,368,515	33,024,394	0.071720
12.	Respiratory Therapy	9,283,503	29,974,433	0.309714
13.	Physical Therapy	5,125,963	17,959,233	0.285422
14.	Occupational Therapy	3,645,195	7,601,492	0.479537
15.	Speech Pathology	2,141,643	3,405,490	0.628880
16.	EKG	11,682,777	54,585,567	0.214027
17.	EEG	3,483,352	9,673,065	0.360108
18.	Med. / Surg. Supplies	264,753	5,309,551	0.049864
19.	Drugs Charged to Patients	52,398,834	291,814,575	0.179562
20.	Renal Dialysis	1,270,225	912,882	1.391445
21.	Renal Dialysis Inpatient	2,256,315	8,192,897	0.275399
22.	Behavioral Health	9,236,811	11,037,555	0.836853
23.	Kidney Acquisition [per W/S D-6]	6,439,424	15,441,360	0.417024
23.01	Liver Acquisition [per W/S D-6]	5,035,886	7,680,000	0.655714
23.02	Heart Acquisition [per W/S D-6]	799,628	180,330	4.434248
23.03	Pancreas Acquisition [per W/S D-6]	290,992	208,911	1.392899
23.04	Psych Day Hospital	3,322,493	4,578,679	0.725644
23.05				
23.06				
23.07				
23.08				
23.09				
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	20,809,396	49,131,394	0.423546
25.	Emergency	15,081,231	49,856,843	0.302491
26.	Observation Beds (Non-distinct Part)	1,108,139	6,274,415	0.176612
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	3,463,527	4,006	864.58
28.				#VALUE!
29.				
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Surgical ICU			
34.	Medical ICU			
35.	Pediatric ICU	7,108,162	4,212	1,687.60
35.01	Perinatal ICU	17,745,299	16,419	1,080.78
35.02				
35.03				
35.04				
35.05				
36.	Nursery	235,548	439	536.56

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

PRELIMINARY

Medicare Provider Number: 14-0119	Public Aid Provider Number: 3047
Program: Medicaid-Children's	Period Covered by Statement: From: 07-01-05 To: 06-30-06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	14,002		14,002
Newborn Days	217		217
Total Inpatient Revenue	78,879,823		78,879,823
Ancillary Revenue	39,631,656		39,631,656
Routine Revenue	39,248,167		39,248,167
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.

Adjusted Routine Days to match W/S S-3 with splits between Acute and Children's facilities.

Adjustment made to include the filed Surgical ICU days & charges ( 11 days & \$35,442) with the Pediatrics ICU days & charges

and charges