

# 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: Lutheran General Hospital		Medicare Provider Number: 14-0223	
Street: 1775 West Dempster Street		Public Aid Provider Number: 16017	
City: Park Ridge	State: Illinois	Zip: 60068	
Period Covered by Statement:	From: 01/01/06	To: 12/31/06	

**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 type="checkbox"/> Medicaid Hospital	<input checked="" type="checkbox"/> Medicaid Sub II Rehabilitation Unit	<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)) Lutheran General Hospital 16017 for the cost report beginning 01/01/06 and ending 12/31/06 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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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	350	127,140		86,780	68.26%		22,356	4.31	
2.	Psychiatric Unit	52	18,980		12,577	66.26%		1,482	8.49	
3.	Rehabilitation Unit	38	13,870		11,933	86.03%		903	13.21	
4.										
5.	Intensive Care Unit	14	5,110		3,913	76.58%				
6.	Coronary Care Unit	20	7,300		5,650	77.40%				
7.	Neonatal Care Unit				18					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	43	15,695		6,893	43.92%				
16.	Total	517	188,095		127,764	67.93%		24,741	4.89	
17.	Observation Bed Days				5,062					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit									
3.	Rehabilitation Unit				560			30	18.67	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal Care Unit									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				560	0.44%		30	18.67	

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:	14-0223	Public Aid Provider Number:	16017
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 01/01/06 To: 12/31/06

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	0.463271	7,040			3,261		
2.	Recovery Room	0.250349						
3.	Delivery and Labor Room	0.467572						
4.	Anesthesiology	0.116174	1,330			155		
5.	Radiology - Diagnostic	0.225517	18,559			4,185		
6.	Radiology - Therapeutic	0.324700	4,131			1,341		
7.	Radioisotope	0.238283	7,959			1,896		
8.	Laboratory	0.214912	35,258			7,577		
9.								
10.	Blood - Administration	0.204416	2,057			420		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.214628	19,830			4,256		
13.	Physical Therapy	0.460020	363,320			167,134		
14.	Occupational Therapy	0.755775	224			169		
15.	Speech Pathology							
16.	EKG	0.152051	2,621			399		
17.	EEG	0.359604						
18.	Med. / Surg. Supplies	0.136154	16,709			2,275		
19.	Drugs Charged to Patients	0.199918	126,197			25,229		
20.	Renal Dialysis	0.391837						
21.	Ambulance							
22.	ASC (Non-distinct Part)	0.319716						
23.	Rehab Medicine	1.163368	25,538			29,710		
23.01	Cardiac Lab	0.288957						
23.02	Diabetes Care Center	6.625901						
23.03	Lithotripter	0.208305						
23.04	Gastroenterology Lab	0.208557						
23.05	Outpatient Center	0.726525	1,176			854		
23.06	Pain Clinic	0.561596						
23.07	Wound Care Center	1.146408						
23.08	Anti Coag Lab	0.519489						
23.09	Heart Risk Assessment	0.727664						
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.344237						
26.	Observation Beds (Non-distinct Part)	0.579845						
27.	<b>Total</b>		631,949			248,861		

\* 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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,032.18	\$ 1,045.96	\$ 708.83	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)			560	
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$	\$ 396,945	\$
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)	\$	\$	\$ 396,945	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,102.74		\$
9.	Coronary Care Unit	\$ 2,205.45		\$
10.	Neonatal Care Unit	\$ 1,223.85		\$
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 442.97		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 248,861
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 645,806</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> 14-0223	<b>Public Aid Provider Number:</b> 16017
<b>Program:</b> Medicaid-Rehabilitation	<b>Period Covered by Statement:</b> From: 01/01/06 To: 12/31/06

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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal Care Unit						
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
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>14-0223</b>	Public Aid Provider Number: <b>16017</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>01/01/06</b> To: <b>12/31/06</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.										
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.	ASC (Non-distinct Part)									
23.	Rehab Medicine									
23.01	Cardiac Lab									
23.02	Diabetes Care Center									
23.03	Lithotripter									
23.04	Gastroenterology Lab									
23.05	Outpatient Center									
23.06	Pain Clinic									
23.07	Wound Care Center									
23.08	Anti Coag Lab									
23.09	Heart Risk Assessment									
<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.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal Care Unit									
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>									

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost  
Computation of Lesser of Reasonable Cost or Customary Charges**

**PRELIMINARY**

<b>Medicare Provider Number:</b> 14-0223	<b>Public Aid Provider Number:</b> 16017
<b>Program:</b> Medicaid-Rehabilitation	<b>Period Covered by Statement:</b> From: 01/01/06 To: 12/31/06

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)	645,806		
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>	645,806		
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)	631,949
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	
	C. Rehabilitation Unit	669,575
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal Care Unit	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	1,301,524
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	655,718
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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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)	645,806		
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)	645,806		
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>	645,806		

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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

**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)	655,718
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: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

**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 Psychiatric Unit	Sub II Rehabilitation Ur	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 Psychiatric Unit	Sub II Rehabilitation Ur	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 Psychiatric Unit	Sub II Rehabilitation Ur	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**

<b>Medicare Provider Number:</b> 14-0223	<b>Public Aid Provider Number:</b> 16017
<b>Program:</b> Medicaid-Rehabilitation	<b>Period Covered by Statement:</b> From: 01/01/06 To: 12/31/06

**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	62,496,290	134,902,208	0.463271
2.	Recovery Room	3,249,631	12,980,422	0.250349
3.	Delivery and Labor Room	9,545,616	20,415,279	0.467572
4.	Anesthesiology	3,205,597	27,593,160	0.116174
5.	Radiology - Diagnostic	31,793,887	140,982,361	0.225517
6.	Radiology - Therapeutic	5,841,261	17,989,729	0.324700
7.	Radioisotope	5,770,473	24,216,875	0.238283
8.	Laboratory	22,587,114	105,099,308	0.214912
9.				
10.	Blood - Administration	2,764,912	13,525,884	0.204416
11.	Intravenous Therapy			
12.	Respiratory Therapy	8,063,478	37,569,564	0.214628
13.	Physical Therapy	6,659,358	14,476,249	0.460020
14.	Occupational Therapy	9,218,857	12,197,890	0.755775
15.	Speech Pathology			
16.	EKG	4,397,651	28,922,169	0.152051
17.	EEG	2,215,730	6,161,588	0.359604
18.	Med. / Surg. Supplies	1,810,194	13,295,175	0.136154
19.	Drugs Charged to Patients	27,875,166	139,433,096	0.199918
20.	Renal Dialysis	1,619,070	4,131,996	0.391837
21.	Ambulance			
22.	ASC (Non-distinct Part)	6,964,385	21,783,068	0.319716
23.	Rehab Medicine	1,775,479	1,526,154	1.163368
23.01	Cardiac Lab	12,502,586	43,267,957	0.288957
23.02	Diabetes Care Center	366,578	55,325	6.625901
23.03	Lithotripter	1,573,167	7,552,233	0.208305
23.04	Gastroenterology Lab	6,041,123	28,966,257	0.208557
23.05	Outpatient Center	551,818	759,531	0.726525
23.06	Pain Clinic	849,711	1,513,029	0.561596
23.07	Wound Care Center	330,960	288,693	1.146408
23.08	Anti Coag Lab	1,478,952	2,846,936	0.519489
23.09	Heart Risk Assessment	762,101	1,047,326	0.727664
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	17,158,635	49,845,400	0.344237
26.	Observation Beds (Non-distinct Part)	4,403,231	7,593,805	0.579845
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	94,797,100	91,842	1,032.18
28.	Psychiatric Unit	13,155,008	12,577	1,045.96
29.	Rehabilitation Unit	8,458,465	11,933	708.83
30.				
31.	Intensive Care Unit	8,228,033	3,913	2,102.74
32.	Coronary Care Unit	12,460,809	5,650	2,205.45
33.	Neonatal Care Unit	22,029	18	1,223.85
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	3,053,371	6,893	442.97

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

PRELIMINARY

Medicare Provider Number: 14-0223	Public Aid Provider Number: 16017
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/06 To: 12/31/06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	560		560
Newborn Days			
Total Inpatient Revenue	1,301,524		1,301,524
Ancillary Revenue	631,949		631,949
Routine Revenue	669,575		669,575
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Filed OHF Supplement No. 2 charges match the filed W/S C charges.

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