

# Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

## General Information

**PRELIMINARY**

Name of Hospital: Children's Hospital of Illinois		Medicare Provider Number: 14-0067	
Street: 530 NE Glen Oak Avenue		Medicaid Provider Number: 16008	
City: Peoria	State: Illinois	Zip: 61637	
Period Covered by Statement:	From: 10/01/2006	To: 09/30/2007	

## 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 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 Hospital

## 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)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/2006 and ending 09/30/2007; 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 Healthcare and Family Services 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: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

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	79	28,835		16,765	58.14%		3,499	9.25	
2.										
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	12	4,380		3,993	91.16%				
6.	Coronary Care Unit									
7.	Premature ICU	35	12,775		11,597	90.78%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total	126	45,990		32,355	70.35%		3,499	9.25	
17.	Observation Bed Days				638					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics			674	9,900			2,290	7.44	
2.										
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				2,247					
6.	Coronary Care Unit									
7.	Premature ICU				4,891					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total			674	17,038	52.66%		2,290	7.44	

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: <b>14-0067</b>	Medicaid Provider Number: <b>16008</b>
Program: <b>Medicaid-Hospital [Children's]</b>	Period Covered by Statement: From: <b>10/01/2006</b> To: <b>09/30/2007</b>

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	0.379059	7,337,082			2,781,187		
2.	Recovery Room	0.162409	592,510			96,229		
3.	Delivery and Labor Room	0.734980						
4.	Anesthesiology	0.052880	3,348,424			177,065		
5.	Radiology - Diagnostic	0.184948	5,671,613			1,048,953		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.090369	10,238,235			925,219		
9.	Blood							
10.	Blood - Administration	0.516828	528,740			273,268		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.119449	11,028,112			1,317,297		
13.	Physical Therapy	0.462076	212,629			98,251		
14.	Occupational Therapy							
15.	Speech Pathology	0.394447	133,298			52,579		
16.	EKG	0.136073	65,203			8,872		
17.	EEG	0.373997	371,178			138,819		
18.	Med. / Surg. Supplies	0.133786	3,893,750			520,929		
19.	Drugs Charged to Patients	0.229552	14,750,775			3,386,070		
20.	Renal Dialysis	0.329231	15,697			5,168		
21.	Ambulance	0.438050	1,584,011			693,876		
22.	Digestive Diseases	0.117554	98,430			11,571		
23.	Cardio Pulmonary Rehab	0.774218						
23.01	Cardiac Catheter Lab	0.230560	1,135,473			261,795		
23.02	Special Clinics	0.637546	2,874			1,832		
23.03	Psychology	0.873247						
23.04	Comp Epilepsy	0.213690	1,941			415		
23.05	Neuro Diagnostic Center	0.527815	1,965			1,037		
23.06	Urological	0.423358						
23.07	Kidney Acquisition( W/S D-6)	1.000000	47,201			47,201		
23.08	Sister's Clinic	1.858940	347			645		
23.09	Sleep Disorders	0.270932						
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency	0.359273	881,940			316,857		
26.	Observation	1.872352	35,449			66,373		
27.	<b>Total</b>		61,976,877			12,231,508		

\* 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: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 934.71	\$	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,900			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 9,253,629	\$	\$	\$
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 (BHF Page 2, Pt. II, Col. 3)	674			
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)	\$ 9,253,629	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,652.86	2,247	\$ 3,713,976
9.	Coronary Care Unit	\$		\$
10.	Premature ICU	\$ 1,321.70	4,891	\$ 6,464,435
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 12,231,508
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 31,663,548</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> 14-0067		<b>Medicaid Provider Number:</b> 16008	
<b>Program:</b> Medicaid-Hospital [Children's]		<b>Period Covered by Statement:</b> From: 10/01/2006 To: 09/30/2007	

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 (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF 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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Premature ICU						
9.	Other						
10.	Other						
10.01	Other						
10.02	Other						
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										
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:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 10/01/2006 To: 09/30/2007

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 (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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	1,479,823	375,390,576	0.003942	5,671,613			22,357		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	22,318	81,943,672	0.000272	11,028,112			3,000		
13.	Physical Therapy	449,037	27,598,469	0.016270	212,629			3,459		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance	5,826	19,059,109	0.000306	1,584,011			485		
22.	Digestive Diseases									
23.	Cardio Pulmonary Rehab	111,330	1,169,688	0.095179						
23.01	Cardiac Catheter Lab									
23.02	Special Clinics	171,436	756,752	0.226542	2,874			651		
23.03	Psychology									
23.04	Comp Epilepsy	388,546	2,976,416	0.130542	1,941			253		
23.05	Neuro Diagnostic Center	286,404	1,676,317	0.170853	1,965			336		
23.06	Urological									
23.07	Kidney Acquisition( W/S D-6)									
23.08	Sister's Clinic	187	2,891,501	0.000065	347					
23.09	Sleep Disorders	443,717	10,717,416	0.041401						
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	2,172,496	74,582,394	0.029129	881,940			25,690		
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	105,307	17,403	6.05	9,900			59,895		
28.										
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit	42,340	3,993	10.60	2,247			23,818		
32.	Coronary Care Unit									
33.	Premature ICU									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	<b>Total</b>							139,944		

\* 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: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	31,663,548		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)	139,944		
5.	Services of Teaching Physicians (BHF 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>	31,803,492		
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)	61,976,877
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	5,903,841
	B.	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	1,801,808
	F. Coronary Care Unit	
	G. Premature ICU	3,141,980
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	72,824,506
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	41,021,014
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: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	31,803,492		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	31,803,492		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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>	31,803,492		

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: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

**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 (BHF Page 7, Line 12)	41,021,014
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 (BHF 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**

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

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

**Part C. Program Cost**

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

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I	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 BHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 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 BHF Page 4, Line 1)				

**Hospital Statement of Cost  
Graduate Medical Education Cost Adjustment Sheet**

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

**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 BHF pgs. 3-4)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	74,679,518	197,012,925	0.379059
2.	Recovery Room	3,390,171	20,874,322	0.162409
3.	Delivery and Labor Room	6,940,930	9,443,697	0.734980
4.	Anesthesiology	3,805,360	71,962,206	0.052880
5.	Radiology - Diagnostic	69,427,683	375,390,576	0.184948
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	32,955,260	364,674,960	0.090369
9.	Blood			
10.	Blood - Administration	5,533,333	10,706,340	0.516828
11.	Intravenous Therapy			
12.	Respiratory Therapy	9,788,077	81,943,672	0.119449
13.	Physical Therapy	12,752,577	27,598,469	0.462076
14.	Occupational Therapy			
15.	Speech Pathology	1,204,380	3,053,335	0.394447
16.	EKG	3,232,347	23,754,423	0.136073
17.	EEG	1,132,269	3,027,482	0.373997
18.	Med. / Surg. Supplies	7,060,582	52,775,024	0.133786
19.	Drugs Charged to Patients	30,540,560	133,044,323	0.229552
20.	Renal Dialysis	1,537,676	4,670,511	0.329231
21.	Ambulance	8,348,840	19,059,109	0.438050
22.	Digestive Diseases	5,374,690	45,720,912	0.117554
23.	Cardio Pulmonary Rehab	905,594	1,169,688	0.774218
23.01	Cardiac Catheter Lab	24,070,845	104,401,847	0.230560
23.02	Special Clinics	482,464	756,752	0.637546
23.03	Psychology	326,667	374,083	0.873247
23.04	Comp Epilepsy	636,030	2,976,416	0.213690
23.05	Neuro Diagnostic Center	884,785	1,676,317	0.527815
23.06	Urological	142,902	337,544	0.423358
23.07	Kidney Acquisition( W/S D-6)	1,723,126	1,723,126	1.000000
23.08	Sister's Clinic	5,375,127	2,891,501	1.858940
23.09	Sleep Disorders	2,903,686	10,717,416	0.270932
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency	26,795,465	74,582,394	0.359273
26.	Observation	1,697,008	906,351	1.872352
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	16,266,844	17,403	934.71
28.				
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	6,599,868	3,993	1,652.86
32.	Coronary Care Unit			
33.	Premature ICU	15,327,774	11,597	1,321.70
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery			

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

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/2006 To: 09/30/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	17,038		17,038
Newborn Days			
Total Inpatient Revenue	72,824,506		72,824,506
Ancillary Revenue	61,976,877		61,976,877
Routine Revenue	10,847,629		10,847,629
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.

Filed OHF Supplement No. 2 charges for Radiology-Diagnostic, Physical Therapy, Special Clinics, Sister's Clinic, Psychology, Sleep Disorders, Operating Room and ER are greater than filed W/S C charges.

Adjusted Professional Component for A&P and ICU to match W/S A-8-2.

Adjusted Total Dept. Costs for A&P and ICU to match W/S B, Pt. 1, Col. 25.