

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: University of Illinois Medical Center at Chicago		Medicare Provider Number: 14-0150
Street: 1740 W. Taylor Street		Medicaid Provider Number: 3098
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 07-01-2006	To: 06-30-2007

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<input type="checkbox"/> Other (Specify) _____

Type of Hospital

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

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input 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)) University of Illinois Medical C 3098 for the cost report beginning 07-01-2006 and ending 06-30-2007 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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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	283	103,373		72,194	69.84%		19,866	5.22	
2.	Psychiatric Unit	46	16,790		12,498	74.44%		1,102	11.34	
3.	Rehabilitation Unit	17	5,175		4,273	82.57%		356	12.00	
4.	Sub III									
5.	Intensive Care Unit	22	8,030		7,040	87.67%				
6.	Coronary Care Unit	19	6,935		5,575	80.39%				
7.	Pediatric ICU	21	7,665		4,536	59.18%				
8.	Neonatal ICU	61	22,117		14,412	65.16%				
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	24	8,760		4,457	50.88%				
16.	Total	493	178,845		124,985	69.88%		21,324	5.65	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				21,617			7,012	5.02	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				742					
6.	Coronary Care Unit				1,284					
7.	Pediatric ICU				2,989					
8.	Neonatal ICU				8,557					
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				3,013					
16.	Total				38,202	30.57%		7,012	5.02	

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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-2006 To: 06-30-2007

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	0.358829	18,976,748			6,809,408		
2.	Recovery Room	0.285933	678,868			194,111		
3.	Delivery and Labor Room	0.512467	11,964,122			6,131,218		
4.	Anesthesiology	0.111158	8,355,037			928,729		
5.	Radiology - Diagnostic,CT Scan,MF	0.168529	22,344,215			3,765,648		
6.	Radiology - Therapeutic	0.458313	447,559			205,122		
7.	Nuclear Medicine	0.352368	488,107			171,993		
8.	Laboratory	0.190890	26,593,039			5,076,345		
9.	Blood							
10.	Blood - Administration	0.331766	7,416,555			2,460,561		
11.	Intravenous Therapy							
12.	Respiratory Therapy/Pulmonary La	0.141913	15,484,770			2,197,490		
13.	Physical Therapy	0.584403	814,974			476,273		
14.	Occupational Therapy	0.657576	257,577			169,376		
15.	Speech Pathology	0.441997	273,857			121,044		
16.	EKG	0.227313	404,376			91,920		
17.	EEG	0.277911	926,927			257,603		
18.	Med. / Surg. Supplies	0.574416	12,183,216			6,998,234		
19.	Drugs Charged to Patients	0.339800	46,996,468			15,969,400		
20.	Renal Dialysis	0.353184	2,039,627			720,364		
21.	Ambulance							
22.	Pancreas Acq	1.011376	168,132			170,045		
23.	Neuro Psych Clinic	1.090937						
23.01	Pulmonary Lab	0.199046						
23.02	Kidney Acquisition	1.052019	1,198,539			1,260,886		
23.03	Liver Acquisition (D-6)	1.077987	494,600			533,172		
23.04	Cardiac Services	0.285123	5,831,333			1,662,647		
23.05	Prosthetics	1.493230	4,006			5,982		
23.06	Other Organ Transplant	1.446078	646,661			935,122		
23.07	Eye Clinic	1.189669	3,246			3,862		
23.08	Primary Care Clinic	0.513245	165,045			84,709		
23.09	Child/Peds & Adolescent Center	0.390871	32,701			12,782		
Outpatient Service Cost Centers								
24.	Clinic/Gastro Services	0.661601	1,450,519			959,665		
25.	Emergency	0.285265	4,684,202			1,336,239		
26.	Observation							
27.	Total		191,325,026			59,709,950		

* 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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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 Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,040.65	\$ 919.84	\$ 765.61	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	21,617			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 22,495,731	\$	\$	\$
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)				
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)	\$ 22,495,731	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,938.78	742	\$ 1,438,575
9.	Coronary Care Unit	\$ 2,157.70	1,284	\$ 2,770,487
10.	Pediatric ICU	\$ 1,886.25	2,989	\$ 5,638,001
11.	Neonatal ICU	\$ 1,392.99	8,557	\$ 11,919,815
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 491.37	3,013	\$ 1,480,498
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 59,709,950
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 105,453,057

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program
PRELIMINARY**

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Pediatric ICU						
9.	Neonatal ICU						
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/Gastro Services										
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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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,CT Scan,MR									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy/Pulmonary Lab									
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.	Pancreas Acq									
23.	Neuro Psych Clinic									
23.01	Pulmonary Lab									
23.02	Kidney Acquisition									
23.03	Liver Acquisition (D-6)									
23.04	Cardiac Services									
23.05	Prosthetics									
23.06	Other Organ Transplant									
23.07	Eye Clinic									
23.08	Primary Care Clinic									
23.09	Child/Peds & Adolescent Center									
Outpatient Ancillary Cost Centers										
24.	Clinic/Gastro Services									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Pediatric ICU									
34.	Neonatal ICU									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total									

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

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

PRELIMINARY

Medicare Provider Number: 14-0150		Medicaid Provider Number: 3098		
Program: Medicaid-Hospital		Period Covered by Statement: From: 07-01-2006 To: 06-30-2007		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	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)	105,453,057		
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)			
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	105,453,057		
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)	191,325,026
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	28,269,202
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	3,325,300
	F. Coronary Care Unit	3,292,826
	G. Pediatric ICU	5,467,143
	H. Neonatal ICU	20,434,980
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	2,328,950
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	254,443,427
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	148,990,370
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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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)	105,453,057		
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)	105,453,057		
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.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	105,453,057		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)			

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 12)	148,990,370
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 (4)	Sum of Columns 1 - 4 (5)
		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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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 Psychiatric Unit	Sub II Rehabilitation Unit	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 Psychiatric Unit	Sub II Rehabilitation Unit	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 Psychiatric Unit	Sub II Rehabilitation Unit	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, 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 BHF Page 4, Line 1)				

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

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

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)
Inpatient Ancillary Centers				
1.	Operating Room	46,411,629	129,341,764	0.358829
2.	Recovery Room	2,115,009	7,396,861	0.285933
3.	Delivery and Labor Room	10,511,969	20,512,472	0.512467
4.	Anesthesiology	4,067,107	36,588,393	0.111158
5.	Radiology - Diagnostic,CT Scan,MRI,Ultrasound,Vascular XRAY	26,659,636	158,190,188	0.168529
6.	Radiology - Therapeutic	6,891,081	15,035,757	0.458313
7.	Nuclear Medicine	2,000,858	5,678,319	0.352368
8.	Laboratory	43,601,900	228,414,231	0.190890
9.	Blood			
10.	Blood - Administration	11,386,486	34,320,801	0.331766
11.	Intravenous Therapy			
12.	Respiratory Therapy/Pulmonary Lab	5,753,725	40,544,012	0.141913
13.	Physical Therapy	4,188,281	7,166,767	0.584403
14.	Occupational Therapy	2,495,012	3,794,255	0.657576
15.	Speech Pathology	1,191,289	2,695,240	0.441997
16.	EKG	675,798	2,972,986	0.227313
17.	EEG	1,372,100	4,937,200	0.277911
18.	Med. / Surg. Supplies	19,765,825	34,410,304	0.574416
19.	Drugs Charged to Patients	52,990,812	155,946,984	0.339800
20.	Renal Dialysis	8,933,109	25,293,058	0.353184
21.	Ambulance			
22.	Pancreas Acq	256,043	253,163	1.011376
23.	Neuro Psych Clinic	6,721,582	6,161,293	1.090937
23.01	Pulmonary Lab	436,223	2,191,564	0.199046
23.02	Kidney Acquisition	4,138,456	3,933,824	1.052019
23.03	Liver Acquisition (D-6)	1,920,735	1,781,779	1.077987
23.04	Cardiac Services	11,282,585	39,570,987	0.285123
23.05	Prosthetics	1,942,066	1,300,581	1.493230
23.06	Other Organ Transplant	1,497,367	1,035,468	1.446078
23.07	Eye Clinic	10,905,386	9,166,743	1.189669
23.08	Primary Care Clinic	4,002,310	7,798,054	0.513245
23.09	Child/Peds & Adolescent Center	4,032,873	10,317,654	0.390871
Outpatient Ancillary Centers				
24.	Clinic/Gastro Services	45,807,862	69,237,941	0.661601
25.	Emergency	11,982,903	42,006,166	0.285265
26.	Observation		4,514,697	
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	75,128,571	72,194	1,040.65
28.	Psychiatric Unit	11,496,121	12,498	919.84
29.	Rehabilitation Unit	3,271,454	4,273	765.61
30.	Sub III			
31.	Intensive Care Unit	13,649,022	7,040	1,938.78
32.	Coronary Care Unit	12,029,187	5,575	2,157.70
33.	Pediatric ICU	8,556,038	4,536	1,886.25
34.	Neonatal ICU	20,075,738	14,412	1,392.99
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	2,190,049	4,457	491.37

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-2006 To: 06-30-2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	35,189		35,189
Newborn Days	3,013		3,013
Total Inpatient Revenue	191,325,026	63,118,401	254,443,427
Ancillary Revenue	191,325,026		191,325,026
Routine Revenue		63,118,401	63,118,401
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:

- Organ Acquisition charges are from W/S D-6, line #51.
- All other OHF Supplement No. 2 charges match the filed W/S C, Column 8 charges.
- Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.
- Total Cost for Observation beds was adjusted to match W/S C, Col. 5.
- Radiology-Diagnostic: Includes Rad. Diag.Line 41), CT Scan 41.03, MRI 41.04,Ultrasound 41.05, Vascular Xray 41.06
- Radiology-Therapeutic is Oncology on Medicare Cost Report.
- Room & Board data came from Cindy Schmiegelt, Provider, on 03/14/2008.