

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: Ingalls Hospital		Medicare Provider Number: 14-0191	
Street: One Ingalls Drive		Medicaid Provider Number: 8006	
City: Harvey	State: Illinois	Zip: 60426	
Period Covered by Statement:	From: 10-01-2006	To: 09-30-2007	

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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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)) Ingalls Hospital 8006 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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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	207	76,057		67,131	88.26%		16,013	4.65	
2.	Psychiatry	32	11,680		5,702	48.82%		1,091	5.23	
3.	Rehabilitation Unit	42	15,572		13,199	84.76%		839	15.73	
4.	Sub III									
5.	Intensive Care Unit	10	3,670		3,090	84.20%				
6.	Coronary Care Unit	15	5,505		4,168	75.71%				
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	26	9,490		3,589	37.82%				
16.	Total	332	121,974		96,879	79.43%		17,943	5.20	
17.	Observation Bed Days				487					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				10,319			3,107	3.57	
2.	Psychiatry									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				305					
6.	Coronary Care Unit				474					
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				1,456					
16.	Total				12,554	12.96%		3,107	3.57	

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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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	0.352057	1,715,003			603,779		
2.	Recovery Room	0.479187	255,060			122,221		
3.	Delivery and Labor Room	1.189512	2,561,727			3,047,205		
4.	Anesthesiology	0.165959	531,783			88,254		
5.	Radiology - Diagnostic	0.456175	590,637			269,434		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.160590	1,035,165			166,237		
8.	Laboratory	0.138165	6,880,201			950,603		
9.	Blood							
10.	Blood - Administration	0.339823	740,524			251,647		
11.	Infusion Therapy	0.195728	1,006,776			197,054		
12.	Respiratory Therapy	0.252259	1,283,807			323,852		
13.	Physical Therapy	0.384420	146,829			56,444		
14.	Occupational Therapy	0.230643	49,710			11,465		
15.	Speech Pathology	0.404697	263,989			106,836		
16.	EKG	0.109016	1,959,646			213,633		
17.	EMG	0.276808	94,063			26,037		
18.	Med. / Surg. Supplies	0.223209	51,904			11,585		
19.	Drugs Charged to Patients	0.293073	4,806,618			1,408,690		
20.	Renal Dialysis	0.510656	255,303			130,372		
21.	Ambulance							
22.	Lithotripsy	0.405366						
23.	FCC Clinic	0.280276	102,479			28,722		
23.01	Ultrasound	0.194335	744,069			144,599		
23.02	CT Scan	0.057142	2,389,909			136,564		
23.03	ASC (Non-distinct Part)	1.733187	259,468			449,707		
23.04	Psych Services	0.492507						
23.05	Retinal Vascular	0.794059						
23.06	Pulmonary Function	0.102325						
23.07	Hemodynamics	0.369252	884,034			326,431		
23.08	Special Procedures	0.247462	1,253,066			310,086		
23.09	MRI	0.127891	902,627			115,438		
Outpatient Service Cost Centers								
24.	Clinic	0.132855	19,510			2,592		
25.	Emergency	0.217099	3,276,598			711,346		
26.	Observation	0.724565						
27.	Total		34,060,505			10,210,833		

* 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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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 Psychiatry	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 719.69	\$ 719.69	\$ 624.47	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,319			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 7,426,481	\$	\$	\$
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)	\$ 7,426,481	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,566.56	305	\$ 477,801
9.	Coronary Care Unit	\$ 1,614.96	474	\$ 765,491
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 471.77	1,456	\$ 686,897
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 10,210,833
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 19,567,503

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

Medicare Provider Number: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: 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.	Psychiatry						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Infusion Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EMG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Lithotripsy									
23.	FCC Clinic									
23.01	Ultrasound									
23.02	CT Scan									
23.03	ASC (Non-distinct Part)									
23.04	Psych Services									
23.05	Retinal Vascular									
23.06	Pulmonary Function									
23.07	Hemodynamics									
23.08	Special Procedures									
23.09	MRI									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatry									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other									
34.	Other									
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: 14-0191		Medicaid Provider Number: 8006	
Program: Medicaid-Hospital		Period Covered by Statement: From: 10-01-2006 To: 09-30-2007	
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)	19,567,503	
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)	19,567,503	
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)	34,060,505
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	8,563,354
	B. Psychiatry	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	568,912
	F. Coronary Care Unit	3,173,183
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	160,619
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	46,526,573
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	26,959,070
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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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)	19,567,503		
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)	19,567,503		
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)	19,567,503		

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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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

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)	26,959,070
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.	Total (Sum of Lines 1 - 3)							

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

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	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 Psychiatry	Sub II Rehabilitation Ur	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 Psychiatry	Sub II Rehabilitation Ur	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 Psychiatry	Sub II Rehabilitation Ur	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: 14-0191	Medicaid Provider Number: 8006	
Program: Medicaid-Hospital	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)
Inpatient Ancillary Centers				
1.	Operating Room	22,584,998	64,151,566	0.352057
2.	Recovery Room	1,611,443	3,362,869	0.479187
3.	Delivery and Labor Room	5,480,662	4,607,489	1.189512
4.	Anesthesiology	1,327,869	8,001,200	0.165959
5.	Radiology - Diagnostic	11,193,116	24,536,879	0.456175
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	2,296,513	14,300,464	0.160590
8.	Laboratory	14,833,538	107,360,697	0.138165
9.	Blood			
10.	Blood - Administration	2,216,704	6,523,106	0.339823
11.	Infusion Therapy	675,160	3,449,485	0.195728
12.	Respiratory Therapy	2,796,647	11,086,418	0.252259
13.	Physical Therapy	8,185,442	21,292,962	0.384420
14.	Occupational Therapy	1,538,190	6,669,150	0.230643
15.	Speech Pathology	872,686	2,156,392	0.404697
16.	EKG	2,578,341	23,651,014	0.109016
17.	EMG	889,367	3,212,941	0.276808
18.	Med. / Surg. Supplies	1,641,993	7,356,292	0.223209
19.	Drugs Charged to Patients	12,923,646	44,097,021	0.293073
20.	Renal Dialysis	1,356,316	2,656,025	0.510656
21.	Ambulance			
22.	Lithotripsy	429,018	1,058,346	0.405366
23.	FCC Clinic	29,147,627	103,995,995	0.280276
23.01	Ultrasound	2,101,211	10,812,313	0.194335
23.02	CT Scan	2,009,304	35,163,173	0.057142
23.03	ASC (Non-distinct Part)	2,584,281	1,491,057	1.733187
23.04	Psych Services	1,268,042	2,574,670	0.492507
23.05	Retinal Vascular	1,149,035	1,447,039	0.794059
23.06	Pulmonary Function	142,217	1,389,860	0.102325
23.07	Hemodynamics	6,227,172	16,864,309	0.369252
23.08	Special Procedures	4,232,192	17,102,360	0.247462
23.09	MRI	2,353,312	18,400,874	0.127891
Outpatient Ancillary Centers				
24.	Clinic	414,469	3,119,702	0.132855
25.	Emergency	9,840,037	45,325,167	0.217099
26.	Observation	355,808	491,064	0.724565
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	48,663,968	67,618	719.69
28.	Psychiatry	4,103,670	5,702	719.69
29.	Rehabilitation Unit	8,242,329	13,199	624.47
30.	Sub III			
31.	Intensive Care Unit	4,840,678	3,090	1,566.56
32.	Coronary Care Unit	6,731,167	4,168	1,614.96
33.	Other			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,693,196	3,589	471.77

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

PRELIMINARY

Medicare Provider Number: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid-Hospital	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,098		11,098
Newborn Days	1,456		1,456
Total Inpatient Revenue	46,531,668	(5,095)	46,526,573
Ancillary Revenue	34,065,600	(5,095)	34,060,505
Routine Revenue	12,466,068		12,466,068
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:

- Filed OHF Supplement No. 2 charges match the filed W/S C charges.
- Radiology-Therapeutic charges on filed report are MRI.
- Reclassified EEG charges as EMG. Determined per cost-to-charge ratio.
- Removed \$5,095 Cardiac Rehab charges. Cardiac Rehab is noncovered for Illinois Medicaid.
- Reclassified Intravenous Therapy charges as Infusion Therapy. Determined per cost-to-charge ratio.
- Adjusted Routine Days to match W/S S-3 with splits between Acute, Psych, and Children's facilities.