

Hospital Statement of Cost

Illinois Department of Public Aid, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Northwestern Memorial Hospital		Medicare Provider Number: 14-0281	
Street: 251 East Huron		Public Aid Provider Number: 3122	
City: Chicago	State: Illinois	Zip: 60611	
Period Covered by Statement:	From: 09/01/03	To: 08/31/04	

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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/03 and ending 08/31/04 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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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	542	198,397		156,646	78.96%		38,718	4.93	
2.	Psychiatric Unit	55	20,130		18,070	89.77%		1,782	10.14	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	67	24,522		21,335	87.00%				
6.	Coronary Care Unit									
7.	Special Care Nursery	48	17,202		12,897	74.97%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	48	17,568		25,832	147.04%				
16.	Total	760	277,819		234,780	84.51%		40,500	5.16	
17.	Observation Bed Days				3,286					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				20,777			3,991	8.06	
2.	Psychiatric Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				3,915					
6.	Coronary Care Unit									
7.	Special Care Nursery				7,459					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,668					
16.	Total				34,819	14.83%		3,991	8.06	

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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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	0.367828	9,760,617			3,590,228		
2.	Recovery Room	0.682645	372,568			254,332		
3.	Delivery and Labor Room	0.398034	9,599,882			3,821,079		
4.	Anesthesiology	0.320315	650,144			208,251		
5.	Radiology - Diagnostic	0.242847	11,144,128			2,706,318		
6.	Radiology - Therapeutic	0.268966	347,704			93,521		
7.	Radioisotope	0.298653	679,418			202,910		
8.	Laboratory	0.239082	13,291,480			3,177,754		
9.	Outside Health Services	0.840513						
10.	Blood - Administration	0.532273	2,554,588			1,359,738		
11.	Kidney Acquisition [per W/S D-6]	0.718068	441,991			317,380		
12.	Respiratory Therapy	0.211577	8,830,438			1,868,318		
13.	Physical Therapy	0.481219	798,887			384,440		
14.	Occupational Therapy	0.474651	245,440			116,498		
15.	Liver Acquisition [per W/S D-6]	0.736116	546,281			402,126		
16.	EKG	0.215625	626,565			135,103		
17.	EEG	0.390008	436,826			170,366		
18.	Med. / Surg. Supplies	1.116585	1,322,129			1,476,269		
19.	Drugs Charged to Patients	0.296693	18,834,569			5,588,085		
20.	Renal Dialysis	0.533268	870,128			464,011		
21.	Pancreas Acquisition [per W/S D-6]	0.779279	29,797			23,220		
22.	Catheterization Lab	0.435494	2,347,490			1,022,318		
23.	Cardiology Graphics	0.309340	969,100			299,781		
23.01	Pulmonary Function Testing	0.252237	66,696			16,823		
23.02	Solid Organ Transplant	2.656431	2,179			5,788		
23.03	MRI	0.157982	1,905,553			301,043		
23.04	Blood Flow Lab	0.209561	639,669			134,050		
23.05	Cellrifuge	0.513368	42,082			21,604		
23.06	Urodynamics	0.628540						
23.07	Cast Room	0.578383	6,535			3,780		
23.08	OB Clinic Services	1.528085	177,146			270,694		
23.09	GI Laboratory	0.332418	424,856			141,230		
Outpatient Service Cost Centers								
24.	Clinic, STD/Aids Clinic, Geriatric Cl	1.837584	18,713			34,387		
25.	Emergency	0.411450	2,372,581			976,198		
26.	Observation	0.468582						
27.	Total		90,356,180			29,587,643		

* 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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 974.48	\$ 769.91	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	20,777			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 20,246,771	\$	\$	\$
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)	\$ 20,246,771	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,904.34	3,915	\$ 7,455,491
9.	Coronary Care Unit	\$		\$
10.	Special Care Nursery	\$ 1,542.23	7,459	\$ 11,503,494
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 119.95	2,668	\$ 320,027
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 29,587,643
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 69,113,426

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

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Special Care Nursery						
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, STD/Aids Clinic, Geriatric										
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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.	Radioisotope									
8.	Laboratory									
9.	Outside Health Services									
10.	Blood - Administration									
11.	Kidney Acquisition [per W/S D-6]									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Liver Acquisition [per W/S D-6]									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Pancreas Acquisition [per W/S D-6]									
22.	Catheterization Lab									
23.	Cardiology Graphics									
23.01	Pulmonary Function Testing									
23.02	Solid Organ Transplant									
23.03	MRI									
23.04	Blood Flow Lab									
23.05	Celltrifuge									
23.06	Urodynamics									
23.07	Cast Room									
23.08	OB Clinic Services									
23.09	GI Laboratory									
Outpatient Ancillary Cost Centers										
24.	Clinic, STD/Aids Clinic, Geriatric Clin									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Special Care Nursery									
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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)	69,113,426		
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)	69,113,426		
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)	90,356,180
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	31,534,593
	B. Psychiatric Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	7,222,884
	F. Coronary Care Unit	
	G. Special Care Nursery	18,424,758
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	2,613,432
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	150,151,847
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	81,038,421
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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)	69,113,426		
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)	69,113,426		
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)	69,113,426		

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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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)	81,038,421
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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 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 Psychiatric Unit	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 Psychiatric Unit	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, 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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/03 To: 08/31/04

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	92,627,608	251,823,311	0.367828
2.	Recovery Room	12,966,867	18,995,037	0.682645
3.	Delivery and Labor Room	21,571,525	54,195,130	0.398034
4.	Anesthesiology	5,656,946	17,660,587	0.320315
5.	Radiology - Diagnostic	62,213,517	256,183,585	0.242847
6.	Radiology - Therapeutic	11,927,660	44,346,297	0.268966
7.	Radioisotope	10,038,980	33,614,190	0.298653
8.	Laboratory	45,629,480	190,853,039	0.239082
9.	Outside Health Services	3,294,302	3,919,396	0.840513
10.	Blood - Administration	15,740,278	29,571,807	0.532273
11.	Kidney Acquisition [per W/S D-6]	10,183,340	14,181,578	0.718068
12.	Respiratory Therapy	10,683,821	50,496,096	0.211577
13.	Physical Therapy	3,930,172	8,167,119	0.481219
14.	Occupational Therapy	1,448,728	3,052,195	0.474651
15.	Liver Acquisition [per W/S D-6]	6,199,544	8,421,963	0.736116
16.	EKG	3,422,371	15,871,884	0.215625
17.	EEG	4,619,333	11,844,213	0.390008
18.	Med. / Surg. Supplies	7,868,066	7,046,542	1.116585
19.	Drugs Charged to Patients	51,541,513	173,720,256	0.296693
20.	Renal Dialysis	4,392,987	8,237,864	0.533268
21.	Pancreas Acquisition [per W/S D-6]	2,222,081	2,851,457	0.779279
22.	Catheterization Lab	25,397,753	58,319,431	0.435494
23.	Cardiology Graphics	5,858,937	18,940,138	0.309340
23.01	Pulmonary Function Testing	1,076,696	4,268,586	0.252237
23.02	Solid Organ Transplant	3,735,112	1,406,064	2.656431
23.03	MRI	13,137,388	83,157,437	0.157982
23.04	Blood Flow Lab	2,047,443	9,770,147	0.209561
23.05	Cellrifuge	1,415,414	2,757,113	0.513368
23.06	Urodynamics	593,385	944,069	0.628540
23.07	Cast Room	99,782	172,519	0.578383
23.08	OB Clinic Services	10,781,378	7,055,483	1.528085
23.09	GI Laboratory	10,758,461	32,364,283	0.332418
Outpatient Ancillary Centers				
24.	Clinic, STD/Aids Clinic, Geriatric Clinic	13,284,511	7,229,337	1.837584
25.	Emergency	21,159,113	51,425,700	0.411450
26.	Observation	2,985,167	6,370,640	0.468582
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	155,851,236	159,932	974.48
28.	Psychiatric Unit	13,912,189	18,070	769.91
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	40,629,000	21,335	1,904.34
32.	Coronary Care Unit			
33.	Special Care Nursery	19,890,112	12,897	1,542.23
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	3,098,439	25,832	119.95

