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: Michael Reese Hospital	**Medicare Provider Number:** 14-0075
Street: 2929 South Ellis Avenue	**Medicaid Provider Number:** 3043
City: Chicago **State:** Illinois	**Zip:** 60616
Period Covered by Statement: **From:** 01/01/04	**To:** 12/31/04

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
[ ]	Church	[ ]	Individual	[ ]	State	[ ]	Township
[ ]	Corporation	[ ]	Partnership	[ ]	City	[ ]	Hospital District
[ ]	Other (Specify)	[XXXX]	Corporation	[ ]	County	[ ]	Other (Specify)

Type of Hospital

[XXXX]	General Short-Term	[ ]	Psychiatric	[ ]	Cancer
[ ]	General Long-Term	[ ]	Rehabilitation	[ ]	Other (Specify)

Health Care Program

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

[ ]	Medicaid Hospital	[XXXX]	Medicaid Sub II Rehabilitation Unit	[ ]	DHS - Office of Rehabilitation Services
[ ]	Medicaid Sub I	[ ]	Medicaid Sub III	[ ]	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)) Michael Reese Hospital 3043 for the cost report beginning 01/01/04 and ending 12/31/04 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	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.

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Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occu-pancy (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	131	47,946		27,882	58.15%		9,958	3.83	
2.	Psychiatry	69	25,254		15,303	60.60%		1,590	9.62	
3.	Rehabilitation Unit	30	10,980		7,977	72.65%		700	11.40	
4.	Sub III									
5.	Intensive Care Unit	53	19,398		8,117	41.84%				
6.	Coronary Care Unit									
7.	Neonatal ICU	33	12,078		2,145	17.76%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	22	8,052		1,706	21.19%				
16.	Total	338	123,708		63,130	51.03%		12,248	5.02	
17.	Observation Bed Days				603					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatry									
3.	Rehabilitation Unit				1,129			89	12.69	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal ICU									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	**Total**				1,129	1.79%		89	12.69	

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)**			

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Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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 Total Billed O/P Charges (Gross) for Health Care Program Patients	Referred O/P E/R Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	Referred O/P E/R O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.294641	2,816			830		
2.	Recovery Room	0.626924						
3.	Delivery and Labor Room	0.603485						
4.	Anesthesiology	0.280636						
5.	Radiology - Diagnostic	0.281904	28,586			8,059		
6.	Radiology - Therapeutic	0.257817	2,524			651		
7.	Nuclear Medicine							
8.	Laboratory	0.149081	72,174			10,760		
9.	Blood							
10.	Blood - Administration	0.473329	2,192			1,038		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.075034	108,880			8,170		
13.	Physical Therapy	0.390680	215,366			84,139		
14.	Occupational Therapy	0.265205	280,612			74,420		
15.	Speech Pathology	0.897399	37,616			33,757		
16.	EKG	0.125391	4,949			621		
17.	EEG	0.709676						
18.	Med. / Surg. Supplies	0.364002	37,787			13,755		
19.	Drugs Charged to Patients	0.224926	221,349			49,787		
20.	Renal Dialysis	0.462390	2,575			1,191		
21.	Ambulance							
22.	Endoscopy	0.300283	11,179			3,357		
23.	Lab Pathology	0.473887	2,584			1,225		
23.01	Pulmonary Lab	0.216717						
23.02	Ultrasound	0.168777	1,401			236		
23.03	MRI	0.096189	17,618			1,695		
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic	0.773014						
25.	Emergency	0.292515						
26.	Observation	0.287486						
27.	**Total**		1,050,208			293,691		

* 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.

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Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0075	3043
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 01/01/04 To: 12/31/04

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)	$ 648.16	$ 378.52	$ 366.29	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,129	
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$	$ 413,541	$
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)	$	$	$ 413,541	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 1,208.45		$
9.	Coronary Care Unit	$		$
10.	Neonatal ICU	$ 951.40		$
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 450.73		$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 293,691
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **707,232**

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

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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.	Psychiatry						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal 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
		(1)	(2)	(3)	(4)	(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)**										

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Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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	503,820	6,539,823	0.077039						
4.	Anesthesiology									
5.	Radiology - Diagnostic	11,658	23,448,843	0.000497	28,586			14		
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Endoscopy									
23.	Lab Pathology									
23.01	Pulmonary Lab									
23.02	Ultrasound									
23.03	MRI									
23.04	Other									
23.05	Other									
23.06	Other									
23.07	Other									
23.08	Other									
23.09	Other									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency	167,020	17,201,963	0.009709						
26.	Observation									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	7,137	28,485	0.25						
28.	Psychiatry									
29.	Rehabilitation Unit	9,032	7,977	1.13	1,129			1,276		
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU	530,000	2,145	247.09						
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	**Total**							1,290		

* 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: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	707,232		
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)	1,290		
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)**	708,522		
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)	1,050,208
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatry	
	C. Rehabilitation Unit	929,661
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal ICU	
	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.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	1,979,869
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,271,347
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: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	708,522		
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)	708,522		
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)**	708,522		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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)	1,271,347
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)	(4)	(5)
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)	(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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0075	**Medicaid Provider Number:** 3043
Program: Medicaid-Rehabilitation	**Period Covered by Statement:** From: 01/01/04 To: 12/31/04

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 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: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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	4,646,281	15,769,284	0.294641
2.	Recovery Room	1,571,243	2,506,273	0.626924
3.	Delivery and Labor Room	3,946,684	6,539,823	0.603485
4.	Anesthesiology	1,993,802	7,104,586	0.280636
5.	Radiology - Diagnostic	6,610,317	23,448,843	0.281904
6.	Radiology - Therapeutic	809,866	3,141,239	0.257817
7.	Nuclear Medicine			
8.	Laboratory	6,363,985	42,688,055	0.149081
9.	Blood			
10.	Blood - Administration	1,755,353	3,708,523	0.473329
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,637,403	21,822,254	0.075034
13.	Physical Therapy	1,252,708	3,206,480	0.390680
14.	Occupational Therapy	804,915	3,035,066	0.265205
15.	Speech Pathology	410,272	457,179	0.897399
16.	EKG	2,205,282	17,587,306	0.125391
17.	EEG	411,026	579,174	0.709676
18.	Med. / Surg. Supplies	6,021,470	16,542,424	0.364002
19.	Drugs Charged to Patients	6,717,116	29,863,728	0.224926
20.	Renal Dialysis	701,334	1,516,759	0.462390
21.	Ambulance			
22.	Endoscopy	1,087,565	3,621,795	0.300283
23.	Lab Pathology	2,344,969	4,948,367	0.473887
23.01	Pulmonary Lab	220,149	1,015,837	0.216717
23.02	Ultrasound	384,307	2,277,015	0.168777
23.03	MRI	292,759	3,043,589	0.096189
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic	4,157,459	5,378,242	0.773014
25.	Emergency	5,031,827	17,201,963	0.292515
26.	Observation	252,217	877,319	0.287486
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	18,462,779	28,485	648.16
28.	Psychiatry	5,792,423	15,303	378.52
29.	Rehabilitation Unit	2,921,931	7,977	366.29
30.	Sub III			
31.	Intensive Care Unit	9,809,002	8,117	1,208.45
32.	Coronary Care Unit			
33.	Neonatal ICU	2,040,750	2,145	951.40
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	768,948	1,706	450.73

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0075	3043
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 01/01/04 To: 12/31/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,129		1,129
Newborn Days			
Total Inpatient Revenue	1,979,869		1,979,869
Ancillary Revenue	1,050,208		1,050,208
Routine Revenue	929,661		929,661
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:

BHF Supplement 2 charges match the Medicare W/S C charges.

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