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: Silver Cross Hospital	Medicare Provider Number: 14-0213
Street: 1200 Maple Road	Public Aid Provider Number: 10004
City: Joliet / State: Illinois	Zip: 60432
Period Covered by Statement: From: 10/01/04	To: 09/30/05

Type of Control

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

Type of Hospital

XXXX 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)

XXXX XXXX	Medicaid Hospital		Medicaid Sub II		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)) Silver Cross Hospital 10004 for the cost report beginning 10/01/04 and ending 09/30/05 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 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.

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Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number:	Public Aid Provider Number:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/04 To: 09/30/05

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	239	87,235		47,544	54.50%		16,337	3.16	
2.	Psychiatric Unit	20	7,320		3,786	51.72%		856	4.42	
3.	Rehabilitation Unit	20	7,320		4,867	66.49%		374	13.01	
4.	Sub III									
5.	Intensive Care Unit	18	6,588		4,044	61.38%				
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	26	9,490		4,685	49.37%				
16.	Total	323	117,953		64,926	55.04%		17,567	3.43	
17.	Observation Bed Days				3,670					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				9,004			4,077	2.21	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				1,645					
16.	**Total**				10,649	16.40%		4,077	2.21	

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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

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	0.163529	1,672,627			273,523		
2.	Recovery Room	0.206569	280,189			57,878		
3.	Delivery and Labor Room	0.953418	2,762,144			2,633,478		
4.	Anesthesiology	0.053990	980,691			52,948		
5.	Radiology - Diagnostic	0.179556	2,851,232			511,956		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.122286	4,357,813			532,900		
9.	Blood							
10.	Blood - Administration	0.355778	550,360			195,806		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.162529	868,795			141,204		
13.	Physical Therapy	0.539765	32,830			17,720		
14.	Occupational Therapy	0.337897	5,191			1,754		
15.	Speech Pathology	0.914186	3,120			2,852		
16.	EKG	0.145788	425,103			61,975		
17.	EEG	0.518437	50,610			26,238		
18.	Med. / Surg. Supplies	0.599216	2,678,863			1,605,218		
19.	Drugs Charged to Patients	0.292365	3,060,015			894,641		
20.	Renal Dialysis	0.282189	103,078			29,087		
21.	Ambulance							
22.	Ultrasound	0.188010	477,018			89,684		
23.	Diabetes Center	1.756355	3,371			5,921		
23.01	Mental Health Unit	1.773357						
23.02	Other							
23.03	Other							
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic	1.972369						
25.	Emergency	0.269437	1,267,881			341,614		
26.	Observation Beds	0.904043						
27.	**Total**		22,430,931			7,476,397		

* 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:	Public Aid Provider Number:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/04 To: 09/30/05

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)	$ 635.28	$ 593.30	$ 834.56	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,004			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 5,720,061	$	$	$
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)	$ 5,720,061	$	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,652.10		$
9.	Coronary Care Unit	$		$
10.	Other	$		$
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 399.92	1,645	$ 657,868
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 7,476,397
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **13,854,326**

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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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

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.	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
		(1)	(2)	(3)	(4)	(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation Beds										
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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

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	8,000	77,922,347	0.000103	4,357,813			449		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy	7,179	9,708,390	0.000739	868,795			642		
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	50,000	7,166,128	0.006977	425,103			2,966		
17.	EEG	5,000	831,810	0.006011	50,610			304		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Ultrasound									
23.	Diabetes Center									
23.01	Mental Health Unit									
23.02	Other									
23.03	Other									
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	260,900	31,884,806	0.008183	1,267,881			10,375		
26.	Observation Beds									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	315,318	51,214	6.16	9,004			55,465		
28.	Psychiatric Unit	4,225	3,786	1.12						
29.	Rehabilitation Unit	2,697	4,867	0.55						
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**							70,201		

* 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:	Public Aid Provider Number:
14-0213	10004
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/04 To: 09/30/05

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)	13,854,326		
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)	70,201		
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)**	13,924,527		
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)	22,430,931
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	4,573,979
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	728,526
	F. Coronary Care Unit	
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	2,155,170
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	29,888,606
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	15,964,079
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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Line No.	Allowable Cost	Inpatient Hospital	Outpatient Organized Clinic	Outpatient Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	13,924,527		
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)	13,924,527		
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)**	13,924,527		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient Organized Clinic	Outpatient 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: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

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)	15,964,079
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: 14-0213	**Public Aid Provider Number:** 10004
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 10/01/04 To: 09/30/05

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 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 Psychiatric Unit**	**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

	1. Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
	(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: 14-0213	Public Aid Provider Number: 10004	
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04	To: 09/30/05

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	9,654,182	59,036,469	0.163529
2.	Recovery Room	1,356,247	6,565,593	0.206569
3.	Delivery and Labor Room	4,438,095	4,654,929	0.953418
4.	Anesthesiology	575,723	10,663,421	0.053990
5.	Radiology - Diagnostic	14,589,516	81,253,248	0.179556
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	9,528,792	77,922,347	0.122286
9.	Blood			
10.	Blood - Administration	1,153,281	3,241,575	0.355778
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,577,891	9,708,390	0.162529
13.	Physical Therapy	2,827,694	5,238,755	0.539765
14.	Occupational Therapy	663,189	1,962,693	0.337897
15.	Speech Pathology	297,616	325,553	0.914186
16.	EKG	1,044,739	7,166,128	0.145788
17.	EEG	431,241	831,810	0.518437
18.	Med. / Surg. Supplies	13,154,360	21,952,618	0.599216
19.	Drugs Charged to Patients	9,159,377	31,328,542	0.292365
20.	Renal Dialysis	10,132,399	35,906,442	0.282189
21.	Ambulance			
22.	Ultrasound	2,151,356	11,442,787	0.188010
23.	Diabetes Center	328,772	187,190	1.756355
23.01	Mental Health Unit	1,043,103	588,208	1.773357
23.02	Other			
23.03	Other			
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic	587,476	297,853	1.972369
25.	Emergency	8,590,934	31,884,806	0.269437
26.	Observation Beds	2,331,478	2,578,945	0.904043
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	32,535,312	51,214	635.28
28.	Psychiatric Unit	2,246,235	3,786	593.30
29.	Rehabilitation Unit	4,061,822	4,867	834.56
30.	Sub III			
31.	Intensive Care Unit	6,681,086	4,044	1,652.10
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	1,873,603	4,685	399.92

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0213	Public Aid Provider Number: 10004
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,004		9,004
Newborn Days	1,645		1,645
Total Inpatient Revenue	29,888,607	(1)	29,888,606
Ancillary Revenue	22,430,932	(1)	22,430,931
Routine Revenue	7,457,675		7,457,675
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 2 charges match the Medicare W/S C charges.

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