

Hospital Statement of Cost

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

General Information

PRELIMINARY

Name of Hospital: Memorial Medical Center [Children's]		Medicare Provider Number: 14-0148	
Street: 701 North First Street		Public Aid Provider Number: 19015	
City: Springfield	State: Illinois	Zip: 62781-0001	
Period Covered by Statement:	From: 10/01/04	To: 09/30/05	

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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) XXXX XXXX	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) XXXX XXXX Children's Hospital

Health Care Program

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

<input type="checkbox"/> Medicaid Hospital XXXX XXXX	<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)) Memorial Medical Center [Chi 19015] 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)
 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: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: 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	2	944		657	69.60%		302	2.37	
2.										
3.										
4.										
5.	Intensive Care Unit	1	365		12	3.29%				
6.	Coronary Care Unit									
7.	Burn ICU	1	365		46	12.60%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	9	3,442		1,226	35.62%				
16.	Total	13	5,116		1,941	37.94%		302	2.37	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				149			82	2.27	
2.										
3.										
4.										
5.	Intensive Care Unit				9					
6.	Coronary Care Unit									
7.	Burn ICU				28					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery				565					
16.	Total				751	38.69%		82	2.27	

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:	14-0148	Public Aid Provider Number:	19015
Program:	Medicaid-Hospital [Children's]	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	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	0.301125	173,557			52,262		
2.	Recovery Room							
3.	Delivery and Labor Room	0.484670						
4.	Anesthesiology	0.088436	100,626			8,899		
5.	Radiology - Diagnostic	0.206442	168,518			34,789		
6.	Radiology - Therapeutic	0.226937						
7.	Nuclear Medicine							
8.	Laboratory	0.271009	134,585			36,474		
9.	Blood							
10.	Blood - Administration	0.386364	19,499			7,534		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.246393	26,082			6,426		
13.	Physical Therapy	0.495223	5,270			2,610		
14.	Occupational Therapy	0.282173	1,873			529		
15.	Speech Pathology	0.340542	278			95		
16.	EKG	0.221726	25,666			5,691		
17.	EEG	0.371807	7,011			2,607		
18.	Med. / Surg. Supplies	0.406927	137,897			56,114		
19.	Drugs Charged to Patients	0.354285	126,680			44,881		
20.	Renal Dialysis	0.287565						
21.	Ambulance							
22.	GI Diagnostics Unit	0.220932	10,016			2,213		
23.	Vascular Lab	0.186092	1,001			186		
23.01	Ambulatory Surgery	0.364777	4,262			1,555		
23.02	Renal Transplant Lab	0.426895						
23.03	Kidney Acquisition	1.000000						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.313460	66,983			20,996		
26.	Observation Beds (Non-distinct Par	0.785409						
27.	Total		1,009,804			283,861		

* 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: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: 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	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 664.69	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	149			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 99,039	\$	\$	\$
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 (OHF 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)	\$ 99,039	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,280.87	9	\$ 11,528
9.	Coronary Care Unit	\$		\$
10.	Burn ICU	\$ 1,148.83	28	\$ 32,167
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 438.63	565	\$ 247,826
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 283,861
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 674,421

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

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	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 (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF 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.							
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.							
10.							
10.01							
10.02							
10.03							
10.04							
10.05							
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 Beds (Non-distinct F										
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:	14-0148	Public Aid Provider Number:	19015
Program:	Medicaid-Hospital [Children's]	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 (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF 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	44,000	74,853,817	0.000588	173,557			102		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	12,750	38,666,096	0.000330	100,626			33		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic	3,000	13,724,740	0.000219						
7.	Nuclear Medicine									
8.	Laboratory	774,603	91,200,918	0.008493	134,585			1,143		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy	116,433	13,827,894	0.008420	5,270			44		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	1,222,466	132,695,401	0.009213	25,666			236		
17.	EEG	41	1,649,601	0.000025	7,011					
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	12,184	6,485,598	0.001879						
21.	Ambulance									
22.	GI Diagnostics Unit									
23.	Vascular Lab	16,968	3,467,249	0.004894	1,001			5		
23.01	Ambulatory Surgery									
23.02	Renal Transplant Lab	36,000	771,126	0.046685						
23.03	Kidney Acquisition	13,246	1,210,074	0.010946						
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency	1,107,141	26,900,451	0.041157	66,983			2,757		
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	371	657	0.57	149			85		
28.										
29.										
30.										
31.	Intensive Care Unit	30	12	2.49	9			22		
32.	Coronary Care Unit									
33.	Burn ICU	59	46	1.29	28			36		
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	20,516	1,226	16.73	565			9,452		
37.	Total							13,915		

* 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: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	674,421		
3.	Interns and Residents Not in an Approved Teaching Program (OHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (OHF Page 6, Line 37, Cols. 6 & 7)	13,915		
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	688,336		
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)	1,009,804
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	107,852
	B.	
	C.	
	D.	
	E. Intensive Care Unit	19,910
	F. Coronary Care Unit	
	G. Burn ICU	48,495
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	452,093
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	1,638,154
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	949,818
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: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	688,336		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	688,336		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF 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)	688,336		

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: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	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 (OHF Page 7, Line 12)	949,818
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to (1)	to (2)	to (3)		
		(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 (OHF Page 7, Line 13)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(4B)
1.	Cost Report Period ended							
2.	Cost Report Period ended							
3.	Cost Report Period ended							
4.	Total (Sum of Lines 1 - 3)							

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

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	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	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I	Sub II	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 OHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 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 OHF Page 4, Line 1)				

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

OHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	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 OHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	22,540,375	74,853,817	0.301125
2.	Recovery Room			
3.	Delivery and Labor Room	3,172,042	6,544,743	0.484670
4.	Anesthesiology	3,419,477	38,666,096	0.088436
5.	Radiology - Diagnostic	25,357,346	122,830,271	0.206442
6.	Radiology - Therapeutic	3,114,650	13,724,740	0.226937
7.	Nuclear Medicine			
8.	Laboratory	24,716,309	91,200,918	0.271009
9.	Blood			
10.	Blood - Administration	4,077,775	10,554,232	0.386364
11.	Intravenous Therapy			
12.	Respiratory Therapy	5,910,280	23,987,167	0.246393
13.	Physical Therapy	6,847,895	13,827,894	0.495223
14.	Occupational Therapy	1,664,042	5,897,238	0.282173
15.	Speech Pathology	692,892	2,034,673	0.340542
16.	EKG	29,421,971	132,695,401	0.221726
17.	EEG	613,333	1,649,601	0.371807
18.	Med. / Surg. Supplies	26,701,767	65,618,142	0.406927
19.	Drugs Charged to Patients	22,604,879	63,804,210	0.354285
20.	Renal Dialysis	1,865,031	6,485,598	0.287565
21.	Ambulance			
22.	GI Diagnostics Unit	2,441,678	11,051,742	0.220932
23.	Vascular Lab	645,226	3,467,249	0.186092
23.01	Ambulatory Surgery	6,180,108	16,942,142	0.364777
23.02	Renal Transplant Lab	329,190	771,126	0.426895
23.03	Kidney Acquisition	1,210,074	1,210,074	1.000000
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	8,432,213	26,900,451	0.313460
26.	Observation Beds (Non-distinct Part)	907,544	1,155,505	0.785409
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	436,704	657	664.69
28.				
29.				
30.				
31.	Intensive Care Unit	15,370	12	1,280.87
32.	Coronary Care Unit			
33.	Burn ICU	52,846	46	1,148.83
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	537,765	1,226	438.63

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

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19015
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	186		186
Newborn Days	565		565
Total Inpatient Revenue	1,638,447	(293)	1,638,154
Ancillary Revenue	1,010,097	(293)	1,009,804
Routine Revenue	628,350		628,350
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:

Removed \$293 of Cardiac Rehab charges from OHF page 3.

OHF Supp. 2 charges for Anesthesiology are greater than the Medicare W/S C charges.