

# 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: 01/01/05	To: 12/31/05	

**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) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

**Type of Hospital**

<input checked="" 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) _____

**Health Care Program**

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

<input checked="" type="checkbox"/> Medicaid Hospital	<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)) Michael Reese Hospital 3043 for the cost report beginning 01/01/05 and ending 12/31/05 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 Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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	128	46,720		21,680	46.40%		8,658	3.88	
2.	Psychiatry	69	25,185		17,068	67.77%		1,690	10.10	
3.	Rehabilitation Unit	30	10,950		7,415	67.72%		675	10.99	
4.	Sub III									
5.	Intensive Care Unit	49	17,885		9,852	55.09%				
6.	Coronary Care Unit									
7.	Neonatal ICU	15	5,475		2,091	38.19%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	20	7,300		1,588	21.75%				
16.	Total	311	113,515		59,694	52.59%		11,023	5.27	
17.	Observation Bed Days				273					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				6,698			2,729	3.68	
2.	Psychiatry									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit				1,800					
6.	Coronary Care Unit									
7.	Neonatal ICU				1,543					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				1,010					
16.	Total				11,051	18.51%		2,729	3.68	

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:	14-0075	Medicaid Provider Number:	3043
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/05 To: 12/31/05

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	0.331960	914,014			303,416		
2.	Recovery Room	0.755386	78,335			59,173		
3.	Delivery and Labor Room	0.720791	3,095,825			2,231,443		
4.	Anesthesiology	0.267200	819,870			219,069		
5.	Radiology - Diagnostic	0.304085	2,543,631			773,480		
6.	Radiology - Therapeutic	0.274889	187,057			51,420		
7.	Nuclear Medicine							
8.	Laboratory	0.157395	6,007,003			945,472		
9.	Blood							
10.	Blood - Administration	0.395325	795,802			314,600		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.083039	5,192,909			431,214		
13.	Physical Therapy	0.526299	80,164			42,190		
14.	Occupational Therapy	0.345185	51,933			17,926		
15.	Speech Pathology	1.187770	16,834			19,995		
16.	EKG	0.175114	1,600,462			280,263		
17.	EEG	1.252338	26,791			33,551		
18.	Med. / Surg. Supplies	0.345550	2,640,312			912,360		
19.	Drugs Charged to Patients	0.248410	6,063,159			1,506,149		
20.	Renal Dialysis	0.338913	480,578			162,874		
21.	Ambulance							
22.	Endoscopy	0.322948	352,981			113,995		
23.	Lab Pathology	0.398556						
23.01	Pulmonary Lab	0.332137	54,978			18,260		
23.02	Ultrasound	0.210431	209,958			44,182		
23.03	MRI	0.149969	192,334			28,844		
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic	0.864258	10,706			9,253		
25.	Emergency	0.250477	1,586,219			397,311		
26.	Observation	0.315019						
27.	<b>Total</b>		33,001,855			8,916,440		

\* 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: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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)	\$ 848.97	\$ 411.03	\$ 400.18	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,698			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 5,686,401	\$	\$	\$
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)	\$ 5,686,401	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,012.28	1,800	\$ 1,822,104
9.	Coronary Care Unit	\$		\$
10.	Neonatal ICU	\$ 1,042.58	1,543	\$ 1,608,701
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 573.68	1,010	\$ 579,417
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 8,916,440
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 18,613,063</b>

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

<b>Medicare Provider Number:</b> 14-0075		<b>Medicaid Provider Number:</b> 3043	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 01/01/05 To: 12/31/05	

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.	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
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

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

PRELIMINARY

Medicare Provider Number:	14-0075	Medicaid Provider Number:	3043
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/05 To: 12/31/05

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	430,576	5,888,720	0.073119	3,095,825			226,364		
4.	Anesthesiology	183,116	6,423,254	0.028508	819,870			23,373		
5.	Radiology - Diagnostic	2,500	22,768,046	0.000110	2,543,631			280		
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									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency	136,534	19,417,413	0.007032	1,586,219			11,154		
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	35,308	21,953	1.61	6,698			10,784		
28.	Psychiatry									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU	520,000	2,091	248.68	1,543			383,713		
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	<b>Total</b>							655,668		

\* 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-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

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)	18,613,063		
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)	655,668		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	19,268,731		
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)	33,001,855
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	6,115,609
	B. Psychiatry	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	4,553,707
	F. Coronary Care Unit	
	G. Neonatal ICU	6,299,149
	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.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	49,970,320
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	30,701,589
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**

<b>Medicare Provider Number:</b> 14-0075	<b>Medicaid Provider Number:</b> 3043
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/05 To: 12/31/05

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	19,268,731		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	19,268,731		
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	19,268,731		

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

**Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges**

<b>Line No.</b>	(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)	30,701,589
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.	<b>Total (Sum of Lines 1 - 3)</b>							

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

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

**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 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**

<b>Medicare Provider Number:</b> 14-0075	<b>Medicaid Provider Number:</b> 3043
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/05 To: 12/31/05

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	5,638,076	16,984,190	0.331960
2.	Recovery Room	1,625,277	2,151,585	0.755386
3.	Delivery and Labor Room	4,244,534	5,888,720	0.720791
4.	Anesthesiology	1,716,296	6,423,254	0.267200
5.	Radiology - Diagnostic	6,923,422	22,768,046	0.304085
6.	Radiology - Therapeutic	752,870	2,738,817	0.274889
7.	Nuclear Medicine			
8.	Laboratory	6,869,715	43,646,395	0.157395
9.	Blood			
10.	Blood - Administration	1,643,872	4,158,277	0.395325
11.	Intravenous Therapy			
12.	Respiratory Therapy	1,926,394	23,198,664	0.083039
13.	Physical Therapy	1,587,880	3,017,066	0.526299
14.	Occupational Therapy	955,659	2,768,540	0.345185
15.	Speech Pathology	444,555	374,277	1.187770
16.	EKG	2,920,253	16,676,293	0.175114
17.	EEG	434,749	347,150	1.252338
18.	Med. / Surg. Supplies	5,097,910	14,753,051	0.345550
19.	Drugs Charged to Patients	6,909,302	27,814,131	0.248410
20.	Renal Dialysis	767,056	2,263,285	0.338913
21.	Ambulance			
22.	Endoscopy	1,123,807	3,479,840	0.322948
23.	Lab Pathology	2,596,325	6,514,332	0.398556
23.01	Pulmonary Lab	347,443	1,046,083	0.332137
23.02	Ultrasound	483,330	2,296,855	0.210431
23.03	MRI	415,928	2,773,425	0.149969
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	5,083,735	5,882,199	0.864258
25.	Emergency	4,863,620	19,417,413	0.250477
26.	Observation	151,442	480,740	0.315019
<b>Routine Service Cost Centers</b>				
			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	18,637,487	21,953	848.97
28.	Psychiatry	7,015,485	17,068	411.03
29.	Rehabilitation Unit	2,967,359	7,415	400.18
30.	Sub III			
31.	Intensive Care Unit	9,973,011	9,852	1,012.28
32.	Coronary Care Unit			
33.	Neonatal ICU	2,180,030	2,091	1,042.58
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	911,007	1,588	573.68

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

PRELIMINARY

Medicare Provider Number: 14-0075	Medicaid Provider Number: 3043
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	10,041		10,041
Newborn Days	1,010		1,010
Total Inpatient Revenue	49,970,320		49,970,320
Ancillary Revenue	33,001,855		33,001,855
Routine Revenue	16,968,465		16,968,465
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Included costs and charges of Radioisotope in Radiology-Therapeutic to agree with filed cost report.

Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.