

Hospital Statement of Cost

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

General Information

PRELIMINARY

Name of Hospital: Northwestern Memorial Hospital		Medicare Provider Number: 14-0281	
Street: 251 East Huron		Public Aid Provider Number: 3122	
City: Chicago	State: Illinois	Zip: 60611	
Period Covered by Statement:	From: 09/01/04	To: 08/31/05	

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 checked="" 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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/04 and ending 08/31/05 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 Public Aid Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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	547	199,580		162,059	81.20%		40,441	4.89	
2.	Psychiatric Unit	55	20,075		16,393	81.66%		1,761	9.31	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	76	27,740		21,800	78.59%				
6.	Coronary Care Unit									
7.	Special Care Nursery	47	17,155		14,057	81.94%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	48	17,520		26,605	151.86%				
16.	Total	773	282,070		240,914	85.41%		42,202	5.08	
17.	Observation Bed Days				3,398					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				21,599			5,899	5.32	
2.	Psychiatric Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				2,400					
6.	Coronary Care Unit									
7.	Special Care Nursery				7,364					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				3,206					
16.	Total				34,569	14.35%		5,899	5.32	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

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

PRELIMINARY

Medicare Provider Number:	14-0281	Public Aid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/04 To: 08/31/05

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	0.410534	9,923,211			4,073,816		
2.	Recovery Room	0.725177	440,491			319,434		
3.	Delivery and Labor Room	0.388426	11,680,749			4,537,107		
4.	Anesthesiology	0.331514	699,593			231,925		
5.	Radiology - Diagnostic	0.246283	11,606,769			2,858,550		
6.	Radiology - Therapeutic	0.225430	496,660			111,962		
7.	Radioisotope	0.303431	529,277			160,599		
8.	Laboratory	0.218982	16,228,593			3,553,770		
9.	Outside Health Services	0.839930	728			611		
10.	Blood - Administration	0.564513	905,652			511,252		
11.	Kidney Acquisition [per W/S D-6]							
12.	Respiratory Therapy	0.208167	9,805,874			2,041,259		
13.	Physical Therapy	0.466165	778,829			363,063		
14.	Occupational Therapy	0.495968	260,236			129,069		
15.	Liver Acquisition [per W/S D-6]							
16.	EKG	0.324852	608,490			197,669		
17.	EEG	0.376557	504,582			190,004		
18.	Transplant Acq(Liver, Kidney, & Pa	0.609609	1,185,189			722,502		
19.	Drugs Charged to Patients	0.219984	19,386,154			4,264,644		
20.	Renal Dialysis	0.541047	973,840			526,893		
21.	Pancreas Acquisition [per W/S D-6]							
22.	Catheterization Lab	0.403457	2,134,423			861,148		
23.	Cardiology Graphics	0.409684	1,133,688			464,454		
23.01	Pulmonary Function Testing	0.272530	71,247			19,417		
23.02	Solid Organ Transplant	1.178742	1,754			2,068		
23.03	MRI	0.218992	2,234,800			489,403		
23.04	Blood Flow Lab	0.200394	690,561			138,384		
23.05	Celltrifuge	0.505616	55,313			27,967		
23.06	Urodynamics	0.551064	1,520			838		
23.07	Cast Room	0.471599	9,961			4,698		
23.08	OB Clinic Services	1.687187						
23.09	GI Laboratory	0.330399	382,950			126,526		
Outpatient Service Cost Centers								
24.	Clinic, STD/Aids Clinic, Geriatric Cl	0.937687	190,242			178,387		
25.	Emergency	0.291155	3,401,045			990,231		
26.	Observation	0.390067						
27.	Total		96,322,421			28,097,650		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,049.04	\$ 895.83	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	21,599			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 22,658,215	\$	\$	\$
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)	\$ 22,658,215	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,360.75	2,400	\$ 5,665,800
9.	Coronary Care Unit	\$		\$
10.	Special Care Nursery	\$ 1,596.03	7,364	\$ 11,753,165
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 160.32	3,206	\$ 513,986
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 28,097,650
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 68,688,816

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

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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.	Psychiatric Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Special Care Nursery						
9.	Other						
10.	Other						
10.01	Other						
10.02	Other						
10.03	Other						
10.04	Other						
10.05	Other						
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic, STD/Aids Clinic, Geriatric										
14.	Emergency										
15.	Observation										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

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

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory									
9.	Outside Health Services									
10.	Blood - Administration									
11.	Kidney Acquisition [per W/S D-6]									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Liver Acquisition [per W/S D-6]									
16.	EKG									
17.	EEG									
18.	Transplant Acq(Liver, Kidney, & Pan									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Pancreas Acquisition [per W/S D-6]									
22.	Catheterization Lab									
23.	Cardiology Graphics									
23.01	Pulmonary Function Testing									
23.02	Solid Organ Transplant									
23.03	MRI									
23.04	Blood Flow Lab									
23.05	Celltrifuge									
23.06	Urodynamics									
23.07	Cast Room									
23.08	OB Clinic Services									
23.09	GI Laboratory									
Outpatient Ancillary Cost Centers										
24.	Clinic, STD/Aids Clinic, Geriatric Clin									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Special Care Nursery									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total									

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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)	68,688,816		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	68,688,816		
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)	96,322,421
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	31,046,550
	B. Psychiatric Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	8,038,918
	F. Coronary Care Unit	
	G. Special Care Nursery	18,481,500
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	2,872,601
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	156,761,990
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	88,073,174
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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)	68,688,816		
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)	68,688,816		
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)	68,688,816		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
7.	Amount Received / Receivable From:			
	A. State Agency			
	B. Other (Patients and Third Party Payors)			
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)			
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)			

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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)	88,073,174
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	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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	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**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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 Psychiatric Unit	Sub II Sub II	Sub III Sub III
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

Part C. Program Cost

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

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part I, Line 26) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1)				

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

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

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)
Inpatient Ancillary Centers				
1.	Operating Room	118,634,195	288,975,585	0.410534
2.	Recovery Room	14,435,597	19,906,303	0.725177
3.	Delivery and Labor Room	25,400,702	65,393,958	0.388426
4.	Anesthesiology	6,580,743	19,850,587	0.331514
5.	Radiology - Diagnostic	75,195,906	305,322,789	0.246283
6.	Radiology - Therapeutic	12,780,905	56,695,550	0.225430
7.	Radioisotope	12,309,008	40,566,112	0.303431
8.	Laboratory	53,881,675	246,055,770	0.218982
9.	Outside Health Services	4,039,093	4,808,847	0.839930
10.	Blood - Administration	5,581,709	9,887,650	0.564513
11.	Kidney Acquisition [per W/S D-6]			
12.	Respiratory Therapy	11,821,320	56,787,782	0.208167
13.	Physical Therapy	3,811,687	8,176,684	0.466165
14.	Occupational Therapy	1,663,106	3,353,250	0.495968
15.	Liver Acquisition [per W/S D-6]			
16.	EKG	5,904,371	18,175,598	0.324852
17.	EEG	4,820,818	12,802,363	0.376557
18.	Transplant Acq(Liver, Kidney, & Pancreas)	16,293,858	26,728,379	0.609609
19.	Drugs Charged to Patients	40,638,057	184,731,972	0.219984
20.	Renal Dialysis	4,930,715	9,113,285	0.541047
21.	Pancreas Acquisition [per W/S D-6]			
22.	Catheterization Lab	26,097,423	64,684,589	0.403457
23.	Cardiology Graphics	9,891,577	24,144,384	0.409684
23.01	Pulmonary Function Testing	1,275,683	4,680,896	0.272530
23.02	Solid Organ Transplant	2,429,968	2,061,492	1.178742
23.03	MRI	22,067,664	100,769,466	0.218992
23.04	Blood Flow Lab	2,275,757	11,356,433	0.200394
23.05	Celltrifuge	1,649,633	3,262,621	0.505616
23.06	Urodynamics	364,780	661,956	0.551064
23.07	Cast Room	107,428	227,795	0.471599
23.08	OB Clinic Services	11,268,597	6,678,924	1.687187
23.09	GI Laboratory	11,462,900	34,694,131	0.330399
Outpatient Ancillary Centers				
24.	Clinic, STD/Aids Clinic, Geriatric Clinic	13,161,173	14,035,784	0.937687
25.	Emergency	22,134,417	76,022,794	0.291155
26.	Observation	3,320,152	8,511,755	0.390067
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	173,570,762	165,457	1,049.04
28.	Psychiatric Unit	14,685,354	16,393	895.83
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	51,464,440	21,800	2,360.75
32.	Coronary Care Unit			
33.	Special Care Nursery	22,435,388	14,057	1,596.03
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	4,265,311	26,605	160.32

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

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/04 To: 08/31/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	31,363		31,363
Newborn Days	3,206		3,206
Total Inpatient Revenue	156,761,990		156,761,990
Ancillary Revenue	96,322,421		96,322,421
Routine Revenue	60,439,569		60,439,569
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 with the exception of Clinic, ER, and Outside Health which were greater than W/S C.

Total Dept. Costs for OR, Recovery Room, Delivery Room, Anesthesiology, Blood-Administration, EEG, Renal Dialysis, Catherization Lab, MRI, Blood Flow Lab, Solid Organ Transplant, Clinic, ER, and Outside Health Services were all adjusted to match W/S B, Pt. 1, Col. 25.

Transplant Acquisition charges come from W/S D-6, line 53 for Kidney, Liver, and Pancreas (17,641,016+7,018,265+2,069,098).

Per filed report, Nursery Beds and Nursery Bed Days available (48 and 17,520) are same as FYE 08/31/2004 and are estimates by Debra Matheny and her supervisor, Shelly Carling. There is no set number of Nursery beds.