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	**Medicare Provider Number:** 14-0148
Street: 701 North First Street	**Public Aid Provider Number:** 19006
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)			
	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
XXXX XXXX	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)

	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
XXXX XXXX	Medicaid Sub I Psychiatric Unit		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)) Memorial Medical Center 19006 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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric	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 Occu-pancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn	Number Of Renal Dialysis Treatments
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	316	115,035		83,567	72.64%		20,311	4.52	
2.	Psychiatric Unit	50	18,250		13,452	73.71%		1,747	7.70	
3.	Rehabilitation Unit	30	10,950		6,945	63.42%		457	15.20	
4.										
5.	Intensive Care Unit	34	12,410		6,164	49.67%				
6.	Coronary Care Unit									
7.	Burn ICU	9	3,285		2,160	65.75%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery	19	6,778		2,414	35.62%				
16.	Total	458	166,708		114,702	68.80%		22,515	4.99	
17.	Observation Bed Days				1,456					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				3,739			577	6.48	
3.	Rehabilitation Unit									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Burn ICU									
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	**Total**				3,739	3.26%		577	6.48	

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: 19006
Program: Medicaid-Psychiatric	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	0.301125	23,063			6,945		
2.	Recovery Room							
3.	Delivery and Labor Room	0.484670						
4.	Anesthesiology	0.088436	17,618			1,558		
5.	Radiology - Diagnostic	0.206442	170,869			35,275		
6.	Radiology - Therapeutic	0.226937						
7.	Nuclear Medicine							
8.	Laboratory	0.271009	597,612			161,958		
9.	Blood							
10.	Blood - Administration	0.386364	392			151		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.246393	14,642			3,608		
13.	Physical Therapy	0.495223	23,041			11,410		
14.	Occupational Therapy	0.282173	8,670			2,446		
15.	Speech Pathology	0.340542	4,922			1,676		
16.	EKG	0.221726	26,789			5,940		
17.	EEG	0.371807	10,616			3,947		
18.	Med. / Surg. Supplies	0.406927	59,334			24,145		
19.	Drugs Charged to Patients	0.354285	339,362			120,231		
20.	Renal Dialysis	0.287565	10,899			3,134		
21.	Ambulance							
22.	GI Diagnostics Unit	0.220932	3,409			753		
23.	Vascular Lab	0.186092	446			83		
23.01	Ambulatory Surgery	0.364777						
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	259,182			81,243		
26.	Observation Beds (Non-distinct Par	0.785409						
27.	**Total**		1,570,866			464,503		

* 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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	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
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 664.69	$ 735.06	$ 497.46	$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)		3,739		
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$ 2,748,389	$	$
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)	$	$ 2,748,389	$	$

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.	Coronary Care Unit	$		$
10.	Burn ICU	$ 1,148.83		$
11.		$		$
12.		$		$
13.		$		$
14.		$		$
15.		$		$
15.01		$		$
15.02		$		$
16.	Nursery	$ 438.63		$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			$ 464,503
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **3,212,892**

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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: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (HCFA 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Psychiatric Unit						
4.	Rehabilitation Unit						
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 Assign-able Time (HCFA 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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 (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: 19006
Program: Medicaid-Psychiatric	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	23,063			14		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	12,750	38,666,096	0.000330	17,618			6		
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	597,612			5,076		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy	116,433	13,827,894	0.008420	23,041			194		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	1,222,466	132,695,401	0.009213	26,789			247		
17.	EEG	41	1,649,601	0.000025	10,616					
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	12,184	6,485,598	0.001879	10,899			20		
21.	Ambulance									
22.	GI Diagnostics Unit									
23.	Vascular Lab	16,968	3,467,249	0.004894	446			2		
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	259,182			10,667		
26.	Observation Beds (Non-distinct Part)									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics	48,049	85,023	0.57						
28.	Psychiatric Unit	9,254	13,452	0.69	3,739			2,580		
29.	Rehabilitation Unit	375	6,945	0.05						
30.										
31.	Intensive Care Unit	15,320	6,164	2.49						
32.	Coronary Care Unit									
33.	Burn ICU	2,786	2,160	1.29						
34.										
35.										
35.01										
35.02										
35.03										
35.04										
35.05										
36.	Nursery	40,396	2,414	16.73						
37.	**Total**							18,806		

* 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:
14-0148	19006
Program: Medicaid-Psychiatric	**Period Covered by Statement:** 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 (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	3,212,892		
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)	18,806		
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)**	3,231,698		
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)	1,570,866
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	3,275,240
	C. Rehabilitation Unit	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Burn ICU	
	H.	
	I.	
	J.	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	4,846,106
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,614,408
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: 19006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Line No.	Allowable Cost	Inpatient Hospital	Outpatient	
			Organized Clinic	Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	3,231,698		
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)	3,231,698		
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)**	3,231,698		

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

* Line 9 DOES NOT APPLY to the Medicaid program.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric	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)	1,614,408
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 (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)	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 **OHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0148	**Public Aid Provider Number:** 19006
Program: Medicaid-Psychiatric	**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**
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 Psychiatric Unit**	**Sub II Rehabilitation Ur**	**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

	1. Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**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 OHF 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 OHF Page 4, Line 1)**				

Hospital Statement of Cost **OHF Supplement No. 2**
Graduate Medical Education Cost Adjustment Sheet
PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric	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	56,514,263	85,023	664.69
28.	Psychiatric Unit	9,888,041	13,452	735.06
29.	Rehabilitation Unit	3,454,828	6,945	497.46
30.				
31.	Intensive Care Unit	7,895,289	6,164	1,280.87
32.	Coronary Care Unit			
33.	Burn ICU	2,481,480	2,160	1,148.83
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,058,863	2,414	438.63

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0148	Public Aid Provider Number: 19006
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10/01/04 To: 09/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,739		3,739
Newborn Days			
Total Inpatient Revenue	4,846,237	(131)	4,846,106
Ancillary Revenue	1,570,997	(131)	1,570,866
Routine Revenue	3,275,240		3,275,240
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 $131 of Cardiac Rehab charges from OHF page 3.

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