

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: St. Mary's Medical Center		Medicare Provider Number: 15-0100
Street: 3700 Washington Avenue		Public Aid Provider Number: 5038
City: Evansville	State: Indiana	Zip: 47750
Period Covered by Statement:	From: 07/01/04	To: 06/30/05

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" 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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I <input checked="" type="checkbox"/> Psychiatric	<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)) St. Mary's Medical Center 5038 for the cost report beginning 07/01/04 and ending 06/30/05 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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	300	109,500		53,111	48.50%		15,259	4.93	
2.	Stress Center	14	5,110		1,051	20.57%		211	4.98	
3.	Rehabilitation Unit	48	17,520		10,787	61.57%		854	12.63	
4.	Sub III									
5.	Intensive Care Unit	45	16,425		11,006	67.01%				
6.	Coronary Care Unit	9	3,285		1,889	57.50%				
7.	Neonatal ICU	32	11,680		9,294	79.57%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	42	15,330		3,736	24.37%				
16.	Total	490	178,850		90,874	50.81%		16,324	5.34	
17.	Observation Bed Days				7,777					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Stress Center				2			1	2.00	
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal ICU									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				2	0.00%		1	2.00	

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:	15-0100	Public Aid Provider Number:	5038
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 07/01/04 To: 06/30/05

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	0.237905						
2.	Recovery Room	0.478487						
3.	Delivery and Labor Room	0.641600						
4.	Anesthesiology	0.163856						
5.	Radiology - Diagnostic	0.281661						
6.	Radiology - Therapeutic	0.365284						
7.	Nuclear Medicine	0.178338						
8.	Laboratory	0.271784	590			160		
9.	Blood							
10.	Blood - Administration	0.571780						
11.	Intravenous Therapy	0.362858						
12.	Respiratory Therapy	0.505306						
13.	Physical Therapy	0.508724						
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.172739	83			14		
17.	EEG	0.415094						
18.	Med. / Surg. Supplies	0.386472	34			13		
19.	Drugs Charged to Patients	0.374043	326			122		
20.	Renal Dialysis	0.486807						
21.	Ambulance	0.748025						
22.	CAT Scan	0.121074						
23.	Diagnostic Ultrasound	0.162930						
23.01								
23.02	Cardiac Cath Lab	0.155414						
23.03	Cardiopulmonary	2.025165						
23.04	Electroconvulsive Therapy	0.969718						
23.05	Outreach Clinic	2.054294						
23.06	Senior Health / Family Practice	1.152992						
23.07	Bariatrics	11.775767						
23.08	Diagnostic Treatment Center	0.820432	119			98		
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.392563						
26.	Observation	0.859281						
27.	Total		1,152			407		

* 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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

Line No.	Description	Adults and Pediatrics	Sub I Stress Center	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 472.65	\$ 960.49	\$ 400.11	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		2		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 1,921	\$	\$
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)	\$	\$ 1,921	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 844.40		\$
9.	Coronary Care Unit	\$ 1,102.92		\$
10.	Neonatal ICU	\$ 703.82		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 233.52		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 407
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,328

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

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Stress Center						
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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room	1,172,218	46,550,508	0.025182						
2.	Recovery Room									
3.	Delivery and Labor Room	334,903	8,680,745	0.038580						
4.	Anesthesiology	2,513,158	3,455,115	0.727373						
5.	Radiology - Diagnostic	11,709	24,054,939	0.000487						
6.	Radiology - Therapeutic									
7.	Nuclear Medicine	359,699	5,656,263	0.063593						
8.	Laboratory	35,141	40,730,786	0.000863	590			1		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy	20	11,782,909	0.000002						
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	229,846	8,090,657	0.028409	83			2		
17.	EEG	115,722	3,274,343	0.035342						
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	24,000	1,486,468	0.016146						
21.	Ambulance									
22.	CAT Scan									
23.	Diagnostic Ultrasound									
23.01										
23.02	Cardiac Cath Lab	107,070	29,291,173	0.003655						
23.03	Cardiopulmonary	37,025	304,711	0.121509						
23.04	Electroconvulsive Therapy	203,895	768,662	0.265260						
23.05	Outreach Clinic	93	411,317	0.000226						
23.06	Senior Health / Family Practice	368,342	1,054,182	0.349410						
23.07	Bariatrics	61,619	58,805	1.047853						
23.08	Diagnostic Treatment Center									
23.09	Other									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency	635,117	29,575,574	0.021474						
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	363,733	60,888	5.97						
28.	Stress Center									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit	20	11,006							
32.	Coronary Care Unit	67,250	1,889	35.60						
33.	Neonatal ICU									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	Total							3		

* 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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	2,328		
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)	3		
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)	2,331		
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)	1,152
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Stress Center	1,730
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal ICU	
	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.	Total Charges for Patient Services (Sum of Lines 8 through 10)	2,882
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	551
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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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)	2,331		
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)	2,331		
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)	2,331		

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: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 12)	551
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.	Total (Sum of Lines 1 - 3)							

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

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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 Stress Center	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 Stress Center	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 Stress Center	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

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	11,074,584	46,550,508	0.237905
2.	Recovery Room	4,059,242	8,483,496	0.478487
3.	Delivery and Labor Room	5,569,567	8,680,745	0.641600
4.	Anesthesiology	566,142	3,455,115	0.163856
5.	Radiology - Diagnostic	6,775,329	24,054,939	0.281661
6.	Radiology - Therapeutic	2,452,117	6,712,897	0.365284
7.	Nuclear Medicine	1,008,727	5,656,263	0.178338
8.	Laboratory	11,069,964	40,730,786	0.271784
9.	Blood			
10.	Blood - Administration	3,620,346	6,331,714	0.571780
11.	Intravenous Therapy	1,936,173	5,335,902	0.362858
12.	Respiratory Therapy	4,173,286	8,258,925	0.505306
13.	Physical Therapy	5,994,251	11,782,909	0.508724
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	1,397,575	8,090,657	0.172739
17.	EEG	1,359,160	3,274,343	0.415094
18.	Med. / Surg. Supplies	39,095,647	101,160,446	0.386472
19.	Drugs Charged to Patients	18,774,964	50,194,632	0.374043
20.	Renal Dialysis	723,623	1,486,468	0.486807
21.	Ambulance	2,324,505	3,107,524	0.748025
22.	CAT Scan	2,372,152	19,592,621	0.121074
23.	Diagnostic Ultrasound	728,577	4,471,710	0.162930
23.01				
23.02	Cardiac Cath Lab	4,552,272	29,291,173	0.155414
23.03	Cardiopulmonary	617,090	304,711	2.025165
23.04	Electroconvulsive Therapy	745,385	768,662	0.969718
23.05	Outreach Clinic	844,966	411,317	2.054294
23.06	Senior Health / Family Practice	1,215,463	1,054,182	1.152992
23.07	Bariatrics	692,474	58,805	11.775767
23.08	Diagnostic Treatment Center	4,050,326	4,936,824	0.820432
23.09	Other			
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	11,610,287	29,575,574	0.392563
26.	Observation	3,519,792	4,096,205	0.859281
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	28,778,701	60,888	472.65
28.	Stress Center	1,009,480	1,051	960.49
29.	Rehabilitation Unit	4,315,993	10,787	400.11
30.	Sub III			
31.	Intensive Care Unit	9,293,495	11,006	844.40
32.	Coronary Care Unit	2,083,418	1,889	1,102.92
33.	Neonatal ICU	6,541,348	9,294	703.82
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	872,418	3,736	233.52

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

PRELIMINARY

Medicare Provider Number: 15-0100	Public Aid Provider Number: 5038
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2		2
Newborn Days			
Total Inpatient Revenue	1,152	1,730	2,882
Ancillary Revenue	1,152		1,152
Routine Revenue		1,730	1,730
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.

Adjusted figures on BHF page 6, Column 1, to match W/S A-8-2.

Most filed medicaid charges came directly from IPCR Summary rather provider records.

Provider neglected to copy Room & Board charges from IPCR to Medicaid Psych report. Will adjust to include this figure.