

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: 09/01/05	To: 08/31/06	

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 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 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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/05 and ending 08/31/06 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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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	532	197,220		167,718	85.04%		41,319	4.97	
2.	Psychiatric Unit	55	20,075		15,926	79.33%		1,674	9.51	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	80	29,200		23,404	80.15%				
6.	Coronary Care Unit									
7.	Special Care Nursery	47	17,155		14,423	84.07%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	114	41,610		27,038	64.98%				
16.	Total	828	305,260		248,509	81.41%		42,993	5.15	
17.	Observation Bed Days				3,184					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatric Unit				5,586			621	9.00	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Special Care Nursery									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				5,586	2.25%		621	9.00	

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:	14-0281	Public Aid Provider Number:	3122
Program:	Medicaid-Psych	Period Covered by Statement:	From: 09/01/05 To: 08/31/06

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	0.364890						
2.	Recovery Room	0.663650						
3.	Delivery and Labor Room	0.385638						
4.	Anesthesiology	0.265342						
5.	Radiology - Diagnostic	0.203468	164,300			33,430		
6.	Radiology - Therapeutic	0.183752						
7.	Radioisotope	0.252878	1,839			465		
8.	Laboratory	0.185619	1,038,999			192,858		
9.	Outside Health Services	0.813486	61			50		
10.	Blood - Administration	0.443092	703			311		
11.	Kidney Acquisition [per W/S D-6]							
12.	Respiratory Therapy	0.192379	1,136			219		
13.	Physical Therapy	0.441756	6,714			2,966		
14.	Occupational Therapy	0.464604	241			112		
15.	Liver Acquisition [per W/S D-6]							
16.	EKG	0.314900	74,187			23,361		
17.	EEG	0.307975	18,161			5,593		
18.	Transplant Acq(Liver, Kidney, & Pa	0.744062						
19.	Drugs Charged to Patients	0.211080	659,182			139,140		
20.	Renal Dialysis	0.457575						
21.	Pancreas Acquisition [per W/S D-6]							
22.	Catheterization Lab	0.349620	10,020			3,503		
23.	Cardiology Graphics	0.342746	4,195			1,438		
23.01	Pulmonary Function Testing	0.251985						
23.02	Solid Organ Transplant	1.038561						
23.03	MRI	0.182165	74,876			13,640		
23.04	Blood Flow Lab	0.166172	8,237			1,369		
23.05	Cellitrifuge	0.516756						
23.06	Urodynamics	0.551064						
23.07	Cast Room	0.416341						
23.08	OB Clinic Services	1.666563						
23.09	GI Laboratory	0.281347	1,489			419		
Outpatient Service Cost Centers								
24.	Clinic, STD/Aids Clinic, Geriatric Cl	1.428847	168,895			241,325		
25.	Emergency	0.256159	588,097			150,646		
26.	Observation	0.619872						
27.	Total		2,821,332			810,845		

* 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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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)	\$ 1,022.71	\$ 928.07	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		5,586		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 5,184,199	\$	\$
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)	\$	\$ 5,184,199	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,310.28		\$
9.	Coronary Care Unit	\$		\$
10.	Special Care Nursery	\$ 1,624.92		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 160.88		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 810,845
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 5,995,044

**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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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-Psych		Period Covered by Statement: From: 09/01/05 To: 08/31/06		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	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)	5,995,044		
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)	5,995,044		
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)	2,821,332
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatric Unit	8,555,243
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Special Care Nursery	
	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)	11,376,575
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	5,381,531
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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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)	5,995,044		
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)	5,995,044		
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)	5,995,044		

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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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)	5,381,531
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: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

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	127,577,943	349,634,126	0.364890
2.	Recovery Room	14,771,669	22,258,211	0.663650
3.	Delivery and Labor Room	26,605,257	68,990,229	0.385638
4.	Anesthesiology	6,488,915	24,454,903	0.265342
5.	Radiology - Diagnostic	79,091,717	388,718,906	0.203468
6.	Radiology - Therapeutic	13,059,589	71,071,743	0.183752
7.	Radioisotope	12,697,886	50,213,480	0.252878
8.	Laboratory	59,105,990	318,426,561	0.185619
9.	Outside Health Services	3,493,380	4,294,331	0.813486
10.	Blood - Administration	6,043,606	13,639,616	0.443092
11.	Kidney Acquisition [per W/S D-6]			
12.	Respiratory Therapy	12,638,118	65,693,729	0.192379
13.	Physical Therapy	4,153,903	9,403,167	0.441756
14.	Occupational Therapy	1,680,797	3,617,698	0.464604
15.	Liver Acquisition [per W/S D-6]			
16.	EKG	6,075,533	19,293,554	0.314900
17.	EEG	4,589,817	14,903,229	0.307975
18.	Transplant Acq(Liver, Kidney, & Pancreas)	17,401,076	23,386,604	0.744062
19.	Drugs Charged to Patients	42,636,946	201,994,141	0.211080
20.	Renal Dialysis	5,033,971	11,001,419	0.457575
21.	Pancreas Acquisition [per W/S D-6]			
22.	Catheterization Lab	26,819,073	76,709,213	0.349620
23.	Cardiology Graphics	10,235,059	29,861,893	0.342746
23.01	Pulmonary Function Testing	1,272,476	5,049,810	0.251985
23.02	Solid Organ Transplant	1,954,493	1,881,925	1.038561
23.03	MRI	22,476,796	123,387,235	0.182165
23.04	Blood Flow Lab	2,383,843	14,345,658	0.166172
23.05	Cellitrifuge	1,595,587	3,087,700	0.516756
23.06	Urodynamics	364,780	661,956	0.551064
23.07	Cast Room	120,004	288,235	0.416341
23.08	OB Clinic Services	11,654,670	6,993,237	1.666563
23.09	GI Laboratory	11,793,013	41,916,264	0.281347
Outpatient Ancillary Centers				
24.	Clinic, STD/Aids Clinic, Geriatric Clinic	11,438,280	8,005,249	1.428847
25.	Emergency	23,358,469	91,187,268	0.256159
26.	Observation	3,030,722	4,889,269	0.619872
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	174,782,456	170,902	1,022.71
28.	Psychiatric Unit	14,780,478	15,926	928.07
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	54,069,764	23,404	2,310.28
32.	Coronary Care Unit			
33.	Special Care Nursery	23,436,211	14,423	1,624.92
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	4,349,786	27,038	160.88

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

PRELIMINARY

Medicare Provider Number: 14-0281	Public Aid Provider Number: 3122
Program: Medicaid-Psych	Period Covered by Statement: From: 09/01/05 To: 08/31/06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,586		5,586
Newborn Days			
Total Inpatient Revenue	11,376,575		11,376,575
Ancillary Revenue	2,821,332		2,821,332
Routine Revenue	8,555,243		8,555,243
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 Transplant Acquisitions, Clinic and ER, which were greater than W/S C.

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

Transplant Acquisition charges come from W/S D-6, line 51 for Kidney, Liver, and Pancreas (14,841,703+6,508,133+2,036,768).