Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Evanston Northwestern Healthcare	**Medicare Provider Number:** 14-0010
Street: 2650 Ridge Avenue	**Medicaid Provider Number:** 5011
City: Evanston **State:** Illinois	**Zip:** 60201
Period Covered by Statement: **From:** 10-01-2006	**To:** 09-30-2007

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
XXXX XXXX	Other (Specify) Community		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		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)) Evanston Northwestern Healt 5011 for the cost report beginning 10-01-2006 and ending 09-30-200 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 Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

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Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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	434	158,410		109,300	69.00%		31,945	4.51	
2.	Psychiatry Unit	29	10,585		7,465	70.52%		1,078	6.92	
3.	Rehabilitation Unit	17	6,205		5,078	81.84%		359	14.14	
4.	Sub III									
5.	Intensive Care Unit	33	12,045		9,009	74.79%				
6.	Coronary Care Unit	30	10,950		8,250	75.34%				
7.	Intensive Care- GB	12	4,380		3,490	79.68%				
8.	ISCU	44	16,060		14,031	87.37%				
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	42	15,330		10,911	71.17%				
16.	Total	641	233,965		167,534	71.61%		33,382	4.69	
17.	Observation Bed Days				16,639					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Psychiatry Unit				577			107	5.39	
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Intensive Care- GB									
8.	ISCU									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	**Total**				577	0.34%		107	5.39	

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)**			

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

PRELIMINARY

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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	0.358619	385			138		
2.	Recovery Room							
3.	Delivery and Labor Room	0.618354	6,075			3,757		
4.	Anesthesiology							
5.	Radiology - Diagnostic	0.391847	9,218			3,612		
6.	Radiology - Therapeutic	0.295044						
7.	Nuclear Medicine	0.272987						
8.	Laboratory	0.229171	195,607			44,827		
9.	Blood							
10.	Blood - Administration	0.423177	1,643			695		
11.	Intravenous Therapy	0.430740	343			148		
12.	Respiratory Therapy	0.193562	5,270			1,020		
13.	Physical Therapy	0.586924	1,886			1,107		
14.	Occupational Therapy	0.536927	659			354		
15.	Speech Pathology	0.460004						
16.	EKG	0.214332	12,916			2,768		
17.	EEG							
18.	Med. / Surg. Supplies	0.716709	788			565		
19.	Drugs Charged to Patients	0.386099	101,988			39,377		
20.	Renal Dialysis	0.344200						
21.	Ambulance							
22.	CT Scan	0.099409	21,134			2,101		
23.	ASC (Non-distinct Part)	1.093178						
23.01	Cardiac Catheter Lab	0.208604						
23.02	Gastrointestinal Unit	0.259856						
23.03	Cancer Care Center	0.585713						
23.04	Child & Adol. Center	1.255766						
23.05	Vascular Lab	0.173548						
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic	1.185694	79			94		
25.	Emergency	0.391040	130,883			51,180		
26.	Observation	0.636588						
27.	**Total**		488,874			151,743		

* 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:	Medicaid Provider Number:
14-0010	5011
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 10-01-2006 To: 09-30-2007

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatry Unit	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 878.21	$ 1,213.44	$ 786.50	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		577		
3.	Program general inpatient routine cost (Line 1 X Line 2)	$	$ 700,155	$	$
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)	$	$ 700,155	$	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 1,777.84		$
9.	Coronary Care Unit	$ 1,021.32		$
10.	Intensive Care- GB	$ 1,842.63		$
11.	ISCU	$ 1,128.10		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 339.52		$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 151,743
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **851,898**

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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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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 (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psychiatry Unit						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Intensive Care- GB						
9.	ISCU						
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 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										
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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	CT Scan									
23.	ASC (Non-distinct Part)									
23.01	Cardiac Catheter Lab									
23.02	Gastrointestinal Unit									
23.03	Cancer Care Center									
23.04	Child & Adol. Center									
23.05	Vascular Lab									
23.06	Other									
23.07	Other									
23.08	Other									
23.09	Other									
	Outpatient Ancillary Cost Centers									
24.	Clinic									
25.	Emergency									
26.	Observation									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics									
28.	Psychiatry Unit									
29.	Rehabilitation Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Intensive Care- GB									
34.	ISCU									
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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient: Organized Clinic	Program Outpatient: Referred Outpatient
		(1)	(2)	(3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	851,898		
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)**	851,898		
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)	488,874
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Psychiatry Unit	744,496
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Intensive Care- GB	
	H. ISCU	
	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)**	1,233,370
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	381,472
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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

Line No.	Allowable Cost	Inpatient Hospital	Outpatient Organized Clinic	Outpatient Referred Outpatient
		(1)	(2)	(3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	851,898		
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)	851,898		
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)**	851,898		

Line No.	Total Amount Received / Receivable	Inpatient Hospital	Outpatient Organized Clinic	Outpatient 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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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)	381,472
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 (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)	(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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0010	**Medicaid Provider Number:** 5011
Program: Medicaid-Psychiatric	**Period Covered by Statement:** From: 10-01-2006 To: 09-30-2007

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psychiatry Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6.	Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

	Part C. Program Cost	**General Service**	**Sub I Psychiatry Unit**	**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

	1. Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psychiatry Unit**	**Sub II Rehabilitation Ur**	**Sub III 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 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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 10-01-2006 To: 09-30-2007

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	110,950,166	309,381,427	0.358619
2.	Recovery Room			
3.	Delivery and Labor Room	21,622,952	34,968,550	0.618354
4.	Anesthesiology			
5.	Radiology - Diagnostic	49,277,538	125,756,930	0.391847
6.	Radiology - Therapeutic	10,692,727	36,241,165	0.295044
7.	Nuclear Medicine	8,611,570	31,545,742	0.272987
8.	Laboratory	49,143,793	214,441,334	0.229171
9.	Blood			
10.	Blood - Administration	4,653,910	10,997,556	0.423177
11.	Intravenous Therapy	3,903,447	9,062,193	0.430740
12.	Respiratory Therapy	10,046,377	51,902,502	0.193562
13.	Physical Therapy	20,760,761	35,372,161	0.586924
14.	Occupational Therapy	3,224,972	6,006,350	0.536927
15.	Speech Pathology	813,671	1,768,836	0.460004
16.	EKG	19,897,579	92,835,123	0.214332
17.	EEG			
18.	Med. / Surg. Supplies	4,673,511	6,520,790	0.716709
19.	Drugs Charged to Patients	81,375,165	210,762,325	0.386099
20.	Renal Dialysis	9,554,613	27,758,876	0.344200
21.	Ambulance			
22.	CT Scan	24,622,706	247,690,327	0.099409
23.	ASC (Non-distinct Part)	9,725,987	8,896,982	1.093178
23.01	Cardiac Catheter Lab	15,340,438	73,538,401	0.208604
23.02	Gastrointestinal Unit	12,788,826	49,215,109	0.259856
23.03	Cancer Care Center	10,004,132	17,080,259	0.585713
23.04	Child & Adol. Center	1,391,274	1,107,909	1.255766
23.05	Vascular Lab	2,676,315	15,421,156	0.173548
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic	43,333,212	36,546,720	1.185694
25.	Emergency	40,121,734	102,602,663	0.391040
26.	Observation	12,400,215	19,479,179	0.636588
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	110,600,653	125,939	878.21
28.	Psychiatry Unit	9,058,336	7,465	1,213.44
29.	Rehabilitation Unit	3,993,824	5,078	786.50
30.	Sub III			
31.	Intensive Care Unit	16,016,556	9,009	1,777.84
32.	Coronary Care Unit	8,425,925	8,250	1,021.32
33.	Intensive Care- GB	6,430,769	3,490	1,842.63
34.	ISCU	15,828,344	14,031	1,128.10
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	3,704,505	10,911	339.52

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0010	5011
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 10-01-2006 To: 09-30-2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	577		577
Newborn Days			
Total Inpatient Revenue	1,233,370		1,233,370
Ancillary Revenue	488,874		488,874
Routine Revenue	744,496		744,496
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:

No adjustment was made to the filed W/S C charges to prepare the filed OHF reports.

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

Included Routine ($3,644) and ICU ($3,421) Room & Board charges on BHF Page 7 with Psych Room & Board