

# 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: Riveredge Hospital		Medicare Provider Number: 14-4009	
Street: 8311 West Roosevelt Road		Medicaid Provider Number: 6036	
City: Forest Park	State: Illinois	Zip: 60130	
Period Covered by Statement:	From: 01/01/04	To: 12/31/04	

## 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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> XXXX XXXX Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

## Type of Hospital

<input type="checkbox"/> General Short-Term	<input type="checkbox"/> XXXX XXXX Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

## Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law**

### CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Riveredge Hospital 6036 for the cost report beginning 01/01/04 and ending 12/31/04 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 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.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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	210	76,860		49,934	64.97%		3,648	13.69	
2.	Sub I									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total	210	76,860		49,934	64.97%		3,648	13.69	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				28,115			1,480	19.00	
2.	Sub I									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				28,115	56.30%		1,480	19.00	

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: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (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	0.504744	673,870			340,132		
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	0.413541	1,404,972			581,014		
20.	Renal Dialysis							
21.	Ambulance							
22.	Other							
23.	Other							
23.01	Other							
23.02	Other							
23.03	Other							
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
<b>Outpatient Service Cost Centers</b>								
24.	Clinic							
25.	Emergency							
26.	Observation							
27.	<b>Total</b>		2,078,842			921,146		

\* 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: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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

Line No.	Description	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 443.53	\$	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	28,115			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 12,469,846	\$	\$	\$
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)	\$ 12,469,846	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$		\$
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 921,146
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 13,390,992</b>

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

<b>Medicare Provider Number:</b> 14-4009	<b>Medicaid Provider Number:</b> 6036
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/04 To: 12/31/04

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.	Sub I						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
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: <b>14-4009</b>	Medicaid Provider Number: <b>6036</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01/01/04</b> To: <b>12/31/04</b>

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.	Other									
23.	Other									
23.01	Other									
23.02	Other									
23.03	Other									
23.04	Other									
23.05	Other									
23.06	Other									
23.07	Other									
23.08	Other									
23.09	Other									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Clinic									
25.	Emergency									
26.	Observation									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics									
28.	Sub I									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	<b>Total</b>									

\* 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: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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)	13,390,992		
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.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)</b>	13,390,992		
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)	2,078,842
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	37,703,883
	B. Sub I	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Other	
	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.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	39,782,725
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	26,391,733
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: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	13,390,992		
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	13,390,992		

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>			

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

PRELIMINARY

Medicare Provider Number: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

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

<b>Line No.</b>	(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)	26,391,733
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.	<b>Total (Sum of Lines 1 - 3)</b>							

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

BHF Supplement No. 1

**PRELIMINARY**

Medicare Provider Number: 14-4009	Medicaid Provider Number: 6036
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/04 To: 12/31/04

**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 Sub I	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 Sub I	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 Sub I	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**

<b>Medicare Provider Number:</b> 14-4009	<b>Medicaid Provider Number:</b> 6036	
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/04	To: 12/31/04

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room			
2.	Recovery Room			
3.	Delivery and Labor Room			
4.	Anesthesiology			
5.	Radiology - Diagnostic			
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	629,210	1,246,592	0.504744
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	1,411,285	3,412,687	0.413541
20.	Renal Dialysis			
21.	Ambulance			
22.	Other			
23.	Other			
23.01.	Other			
23.02.	Other			
23.03.	Other			
23.04.	Other			
23.05.	Other			
23.06.	Other			
23.07.	Other			
23.08.	Other			
23.09.	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic			
25.	Emergency			
26.	Observation			
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	22,147,379	49,934	443.53
28.	Sub I			
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Other			
34.	Other			
35.	Other			
35.01.	Other			
35.02.	Other			
35.03.	Other			
35.04.	Other			
35.05.	Other			
36.	Nursery			

