# 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:** The Finley Hospital | **Medicare Provider Number:** 16-0117 |
| **Street:** 350 N. Grandview Avenue | **Medicaid Provider Number:** 4010 |
| **City:** Dubuque **State:** Iowa | **Zip:** 52001 |
| **Period Covered by Statement:** **From:** 01-01-2006 | **To:** 12-31-2006 |

## Type of Control

| Voluntary Nonprofit | | Proprietary | | Government (Non-Federal) | | | |
|---|---|---|---|---|---|---|---|
| | Church | | Individual | | State | | Township |
| XXXX XXXX | Corporation | | Partnership | | City | | Hospital District |
| | Other (Specify) | | Corporation | | County | | Other (Specify) |

## Type of Hospital

| | | | | | |
|---|---|---|---|---|---|
| XXXX XXXX | General Short-Term | | Psychiatric | | Cancer |
| | General Long-Term | | Rehabilitation | | Other (Specify) |

## Health Care Program

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

| | | | | | |
|---|---|---|---|---|---|
| XXXX XXXX | Medicaid Hospital | | Medicaid Sub II | | DHS - Office of Rehabilitation Services |
| | Medicaid Sub I | | 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)) The Finley Hospital 4010 for the cost report beginning 01-01-2006 and ending 12-31-200 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Signed (Officer or Administrator of Provider(s)):

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.

Rev. 7 / 05

## Hospital Statement of Cost / Statistical Data



PRELIMINARY

| Medicare Provider Number: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| 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 | 88 | 32,120 | | 15,285 | 47.59% | | 4,185 | 4.08 | |
| 2. | Mental Health Unit | 9 | 3,285 | | 1,626 | 49.50% | | 180 | 9.03 | |
| 3. | Rehabilitation Unit | 10 | 3,650 | | 2,051 | 56.19% | | 178 | 11.52 | |
| 4. | Sub III | | | | | | | | | |
| 5. | Intensive Care Unit | 10 | 3,650 | | 1,785 | 48.90% | | | | |
| 6. | Coronary Care Unit | | | | | | | | | |
| 7. | Other | | | | | | | | | |
| 8. | Other | | | | | | | | | |
| 9. | Other | | | | | | | | | |
| 10. | Other | | | | | | | | | |
| 11. | Other | | | | | | | | | |
| 12. | Other | | | | | | | | | |
| 13. | Other | | | | | | | | | |
| 14. | Other | | | | | | | | | |
| 15. | Newborn Nursery | 12 | 4,380 | | 1,704 | 38.90% | | | | |
| 16. | Total | 129 | 47,085 | | 22,451 | 47.68% | | 4,543 | 4.57 | |
| 17. | Observation Bed Days | | | | 1,241 | | | | | |

| | **Part II-Program** | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Adults and Pediatrics | | | | 46 | | | 43 | 1.30 | |
| 2. | Mental Health Unit | | | | | | | | | |
| 3. | Rehabilitation Unit | | | | | | | | | |
| 4. | Sub III | | | | | | | | | |
| 5. | Intensive Care Unit | | | | 10 | | | | | |
| 6. | Coronary Care Unit | | | | | | | | | |
| 7. | Other | | | | | | | | | |
| 8. | Other | | | | | | | | | |
| 9. | Other | | | | | | | | | |
| 10. | Other | | | | | | | | | |
| 11. | Other | | | | | | | | | |
| 12. | Other | | | | | | | | | |
| 13. | Other | | | | | | | | | |
| 14. | Other | | | | | | | | | |
| 15. | Newborn Nursery | | | | 35 | | | | | |
| **16.** | **Total** | | | | 91 | 0.41% | | 43 | 1.30 | |

| 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)** | | | |

Rev. 7 / 05

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



PRELIMINARY

| Medicare Provider Number: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| 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 | 0.277523 | 5,956 | | | 1,653 | | |
| 2. | Recovery Room | | | | | | | |
| 3. | Delivery and Labor Room | 0.715361 | 40,880 | | | 29,244 | | |
| 4. | Anesthesiology | 0.108511 | 1,082 | | | 117 | | |
| 5. | Radiology - Diagnostic | 0.269166 | 5,826 | | | 1,568 | | |
| 6. | Radiology - Therapeutic | | | | | | | |
| 7. | Nuclear Medicine | | | | | | | |
| 8. | Laboratory | 0.345907 | 16,485 | | | 5,702 | | |
| 9. | Blood | | | | | | | |
| 10. | Blood - Administration | | | | | | | |
| 11. | Intravenous Therapy | | | | | | | |
| 12. | Respiratory Therapy | 0.337304 | 9,432 | | | 3,181 | | |
| 13. | Physical Therapy | 0.561497 | | | | | | |
| 14. | Occupational Therapy | | | | | | | |
| 15. | Speech Pathology | | | | | | | |
| 16. | EKG | | | | | | | |
| 17. | EEG | | | | | | | |
| 18. | Med. / Surg. Supplies | 0.504537 | 1,734 | | | 875 | | |
| 19. | Drugs Charged to Patients | 0.324926 | 16,508 | | | 5,364 | | |
| 20. | Renal Dialysis | 1.290232 | | | | | | |
| 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 | | | | | | | |
| | **Outpatient Service Cost Centers** | | | | | | | |
| 24. | Clinic | | | | | | | |
| 25. | Emergency | 0.712008 | 3,432 | | | 2,444 | | |
| 26. | Observation | 0.710368 | | | | | | |
| **27.** | **Total** | | 101,335 | | | 50,148 | | |

* 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.

Rev. 7 / 05

## Hospital Statement of Cost / Computation of Inpatient Operating Cost



PRELIMINARY

| Medicare Provider Number: | Medicaid Provider Number: |
|---|---|
| 16-0117 | 4010 |
| **Program:** | **Period Covered by Statement:** |
| Medicaid-Hospital | From: 01-01-2006 To: 12-31-2006 |

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

| Line No. | Description | Adults and Pediatrics | Sub I Mental Health Unit | Sub II Rehabilitation Unit | Sub III Sub III |
|---|---|---|---|---|---|
| 1. | Adjusted general inpatient routine service cost per diem (See Instructions) | $ 537.13 | $ 948.98 | $ 757.33 | $ |
| 2. | Program general inpatient routine days (BHF Page 2, Part II, Col. 4) | 46 | | | |
| 3. | Program general inpatient routine cost (Line 1 X Line 2) | $ 24,708 | $ | $ | $ |
| 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) | $ 24,708 | $ | $ | $ |

| Line No. | Description | Average Per Diem (See Instructions) (A) | Program Days (B) | Program Cost (Col. A X Col. B) (C) |
|---|---|---|---|---|
| 8. | Intensive Care Unit | $ 1,048.22 | 10 | $ 10,482 |
| 9. | Coronary Care Unit | $ | | $ |
| 10. | Other | $ | | $ |
| 11. | Other | $ | | $ |
| 12. | Other | $ | | $ |
| 13. | Other | $ | | $ |
| 14. | Other | $ | | $ |
| 15. | Other | $ | | $ |
| 15.01 | Other | $ | | $ |
| 15.02 | Other | $ | | $ |
| 16. | Nursery | $ 464.47 | 35 | $ 16,256 |
| 17. | Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27) | | | $ 50,148 |
| **18.** | **Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)** | | | $ **101,594** |

Rev. 7 / 05

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

PRELIMINARY

| Medicare Provider Number: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| 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. | Mental Health Unit | | | | | | |
| 4. | Rehabilitation Unit | | | | | | |
| 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 |
| | | (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: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| 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 | | | | | | | | | |
| | **Outpatient Ancillary Cost Centers** | | | | | | | | | |
| 24. | Clinic | | | | | | | | | |
| 25. | Emergency | 1,650,294 | 4,348,430 | 0.379515 | 3,432 | | | 1,302 | | |
| 26. | Observation | | | | | | | | | |
| | **Routine Service Cost Centers** | | **Days** | **Per Diem** | **Days** | | | | | |
| 27. | Adults and Pediatrics | | | | | | | | | |
| 28. | Mental Health Unit | | | | | | | | | |
| 29. | Rehabilitation Unit | | | | | | | | | |
| 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. | **Total** | | | | | | | 1,302 | | |

* 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: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| 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) | 101,594 | | |
| 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) | 1,302 | | |
| 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)** | 102,896 | | |
| 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) | 101,335 |
| 9. | Inpatient Routine Services (Provider's Records) | |
| | A. Adults and Pediatrics | 31,266 |
| | B. Mental Health Unit | |
| | C. Rehabilitation Unit | |
| | D. Sub III | |
| | E. Intensive Care Unit | 11,597 |
| | F. Coronary Care Unit | |
| | G. Other | |
| | H. Other | |
| | I. Other | |
| | J. Other | |
| | K. Other | |
| | L. Other | |
| | M. Other | |
| | N. Other | |
| | O. Nursery | 27,501 |
| 10. | Services of Teaching Physicians (Provider's Records) | |
| **11.** | **Total Charges for Patient Services (Sum of Lines 8 through 10)** | 171,699 |
| 12. | Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3) | 68,803 |
| 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: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

| Line No. | Allowable Cost | Inpatient Hospital | Outpatient | |
|---|---|---|---|---|
| | | | Organized Clinic | Referred Outpatient |
| | | (1) | (2) | (3) |
| 1. | Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3) | 102,896 | | |
| 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) | 102,896 | | |
| 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)** | 102,896 | | |

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 7 / 05

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



PRELIMINARY

| Medicare Provider Number: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

### 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) | 68,803 |
| 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:** 16-0117 | **Medicaid Provider Number:** 4010 |
| **Program:** Medicaid-Hospital | **Period Covered by Statement:** From: 01-01-2006 To: 12-31-2006 |

## 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 Mental Health Ur** | **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 Mental Health Ur** | **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 Mental Health Ur** | **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: 16-0117 | Medicaid Provider Number: 4010 |
|---|---|
| Program: Medicaid-Hospital | Period Covered by Statement: From: 01-01-2006 To: 12-31-2006 |

**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 | 9,794,586 | 35,292,870 | 0.277523 |
| 2. | Recovery Room | | | |
| 3. | Delivery and Labor Room | 1,216,960 | 1,701,182 | 0.715361 |
| 4. | Anesthesiology | 616,249 | 5,679,124 | 0.108511 |
| 5. | Radiology - Diagnostic | 8,431,126 | 31,323,167 | 0.269166 |
| 6. | Radiology - Therapeutic | | | |
| 7. | Nuclear Medicine | | | |
| 8. | Laboratory | 3,134,277 | 9,061,030 | 0.345907 |
| 9. | Blood | | | |
| 10. | Blood - Administration | | | |
| 11. | Intravenous Therapy | | | |
| 12. | Respiratory Therapy | 1,554,325 | 4,608,081 | 0.337304 |
| 13. | Physical Therapy | 3,726,626 | 6,636,944 | 0.561497 |
| 14. | Occupational Therapy | | | |
| 15. | Speech Pathology | | | |
| 16. | EKG | | | |
| 17. | EEG | | | |
| 18. | Med. / Surg. Supplies | 6,396,742 | 12,678,434 | 0.504537 |
| 19. | Drugs Charged to Patients | 3,654,515 | 11,247,213 | 0.324926 |
| 20. | Renal Dialysis | 369,921 | 286,709 | 1.290232 |
| 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 | | | |
| | **Outpatient Ancillary Centers** | | | |
| 24. | Clinic | | | |
| 25. | Emergency | 3,096,116 | 4,348,430 | 0.712008 |
| 26. | Observation | 666,578 | 938,356 | 0.710368 |
| | **Routine Service Cost Centers** | | **Total Days** | **Per Diem** |
| 27. | Adults and Pediatrics | 8,876,643 | 16,526 | 537.13 |
| 28. | Mental Health Unit | 1,543,045 | 1,626 | 948.98 |
| 29. | Rehabilitation Unit | 1,553,274 | 2,051 | 757.33 |
| 30. | Sub III | | | |
| 31. | Intensive Care Unit | 1,871,066 | 1,785 | 1,048.22 |
| 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 | 791,462 | 1,704 | 464.47 |

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

**PRELIMINARY**

| Medicare Provider Number: | Medicaid Provider Number: |
|---|---|
| 16-0117 | 4010 |
| **Program:** | **Period Covered by Statement:** |
| Medicaid-Hospital | From: 01-01-2006 To: 12-31-2006 |

| Inpatient Reconciliation | Provider's Records | Adjustments | Audited Cost Report |
|---|---|---|---|
| Adult Days | 56 | | 56 |
| Newborn Days | 35 | | 35 |
| Total Inpatient Revenue | 171,699 | | 171,699 |
| Ancillary Revenue | 101,335 | | 101,335 |
| Routine Revenue | 70,364 | | 70,364 |
| 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 No. charges match the filed W/S C charges.

Rev. 7 / 05