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: Copley Memorial Hospital	**Medicare Provider Number:** 14-0029
Street: 2000 Ogden Avenue	**Medicaid Provider Number:** 1007
City: Aurora **State:** Illinois	**Zip:** 60504
Period Covered by Statement: **From:** 7-01-2006	**To:** 6-30-2007

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)) Copley Memorial Hospital 1007 for the cost report beginning 7-01-2006 and ending 6-30-2007 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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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	144	52,560		36,505	69.45%		12,267	3.44	
2.	Rehabilitation Unit	18	6,570		3,399	51.74%		427	7.96	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	12	4,380		3,391	77.42%				
6.	Coronary Care Unit									
7.	NICU	9	3,285		2,262	68.86%				
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	24	8,760		9,049	103.30%				
16.	Total	207	75,555		54,606	72.27%		12,694	3.59	
17.	Observation Bed Days				2,325					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				9,893			4,914	2.30	
2.	Rehabilitation Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				253					
6.	Coronary Care Unit									
7.	NICU				1,140					
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,912					
16.	**Total**				14,198	26.00%		4,914	2.30	

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)**			

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

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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	0.227362	4,889,861			1,111,769		
2.	Recovery Room	0.184978	358,615			66,336		
3.	Delivery and Labor Room	0.274573	12,330,408			3,385,597		
4.	Anesthesiology	0.115000	1,263,116			145,258		
5.	Radiology - Diagnostic	0.144739	3,296,554			477,140		
6.	Radiology - Therapeutic	0.241538	111,530			26,939		
7.	Nuclear Medicine							
8.	Laboratory	0.113214	7,852,026			888,959		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.147279	3,755,553			553,114		
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.157162	510,304			80,200		
17.	EEG							
18.	Med. / Surg. Supplies	0.039598	4,644,294			183,905		
19.	Drugs Charged to Patients	0.178304	8,481,432			1,512,273		
20.	Renal Dialysis	0.329561	124,256			40,950		
21.	Ambulance							
22.	Same Day Surgery	0.391822	52,629			20,621		
23.	G.I. Lab	0.191209	220,095			42,084		
23.01	Rehab Services	0.256510	166,548			42,721		
23.02	CV Surgery	0.595337	324,318			193,079		
23.03	Vascular Services	0.290853	1,294,231			376,431		
23.04	Other							
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic	0.135082	26,552			3,587		
25.	Emergency	0.221166	1,474,488			326,107		
26.	Observation	0.582261						
27.	**Total**		51,176,810			9,477,070		

* 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:
14-0029	1007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 7-01-2006 To: 6-30-2007

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 851.10	$ 849.58	$	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,893			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 8,419,932	$	$	$
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)	$ 8,419,932	$	$	$

Line No.	Description	Average Per Diem (See Instructions) (A)	Program Days (B)	Program Cost (Col. A X Col. B) (C)
8.	Intensive Care Unit	$ 1,633.50	253	$ 413,276
9.	Coronary Care Unit	$		$
10.	NICU	$ 2,828.92	1,140	$ 3,224,969
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$ 235.81	2,912	$ 686,679
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 9,477,070
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			**$ 22,221,926**

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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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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.	Rehabilitation Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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.	Same Day Surgery									
23.	G.I. Lab									
23.01	Rehab Services									
23.02	CV Surgery									
23.03	Vascular Services									
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									
26.	Observation									
	Routine Service Cost Centers		**Days**	**Per Diem**	**Days**					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	NICU									
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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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)	22,221,926		
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)**	22,221,926		
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)	51,176,810
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	8,563,039
	B. Rehabilitation Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	662,068
	F. Coronary Care Unit	
	G. NICU	7,628,203
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	519,751
10.	Services of Teaching Physicians (Provider's Records)	
11.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	68,549,871
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	46,327,945
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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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)	22,221,926		
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)	22,221,926		
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)**	22,221,926		

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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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)	46,327,945
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: 14-0029	**Medicaid Provider Number:** 1007
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 7-01-2006 To: 6-30-2007

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 Rehabilitation Ur**	**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 Rehabilitation Ur**	**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

	Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Rehabilitation Ur**	**Sub II Sub II**	**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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

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	23,152,158	101,829,433	0.227362
2.	Recovery Room	1,417,535	7,663,275	0.184978
3.	Delivery and Labor Room	7,651,406	27,866,578	0.274573
4.	Anesthesiology	1,083,063	9,417,966	0.115000
5.	Radiology - Diagnostic	16,894,685	116,725,518	0.144739
6.	Radiology - Therapeutic	4,622,383	19,137,322	0.241538
7.	Nuclear Medicine			
8.	Laboratory	11,111,480	98,146,095	0.113214
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	3,127,934	21,238,108	0.147279
13.	Physical Therapy			
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	1,659,524	10,559,301	0.157162
17.	EEG			
18.	Med. / Surg. Supplies	1,072,882	27,094,517	0.039598
19.	Drugs Charged to Patients	18,726,036	105,023,013	0.178304
20.	Renal Dialysis	661,824	2,008,198	0.329561
21.	Ambulance			
22.	Same Day Surgery	2,965,800	7,569,246	0.391822
23.	G.I. Lab	1,769,414	9,253,810	0.191209
23.01	Rehab Services	3,147,076	12,268,816	0.256510
23.02	CV Surgery	3,772,351	6,336,494	0.595337
23.03	Vascular Services	11,446,684	39,355,630	0.290853
23.04	Other			
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic	880,464	6,518,016	0.135082
25.	Emergency	12,780,634	57,787,592	0.221166
26.	Observation	1,881,320	3,231,060	0.582261
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	33,048,205	38,830	851.10
28.	Rehabilitation Unit	2,887,706	3,399	849.58
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	5,539,207	3,391	1,633.50
32.	Coronary Care Unit			
33.	NICU	6,399,027	2,262	2,828.92
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	2,133,819	9,049	235.81

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-2006 To: 6-30-2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,286		11,286
Newborn Days	2,912		2,912
Total Inpatient Revenue	68,549,871		68,549,871
Ancillary Revenue	51,176,810		51,176,810
Routine Revenue	17,373,061		17,373,061
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. 2 charges match the file Medicare W/S C charges.