

# 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: Anderson Hospital		Medicare Provider Number: 14-0289	
Street: 6800 State Route 162, P.O. Box 1000		Medicaid Provider Number: 13047	
City: Maryville	State: Illinois	Zip: 62062-1000	
Period Covered by Statement:	From: 01-01-07	To: 12-31-07	

## Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation XXXX XXXX	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

## Type of Hospital

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

## Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital XXXX XXXX	<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)) Anderson Hospital 13047 for the cost report beginning 01-01-07 and ending 12-31-07 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: 14-0289	Medicaid Provider Number: 13047
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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	108	39,420		24,796	62.90%		7,628	3.34	
2.	Rehabilitation Unit	15	5,475		3,462	63.23%		279	12.41	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	7	2,555		660	25.83%				
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	15	5,475		3,809	69.57%				
16.	Total	145	52,925		32,727	61.84%		7,907	3.66	
17.	Observation Bed Days				1,326					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				2,735			960	2.87	
2.	Rehabilitation Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				21					
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				1,327					
16.	Total				4,083	12.48%		960	2.87	

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: <b>14-0289</b>	Medicaid Provider Number: <b>13047</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01-01-07</b> To: <b>12-31-07</b>

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) <b>(1)</b>	Total Billed I/P Charges (Gross) for Health Care Program Patients <b>(2)</b>	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) <b>(5)</b>	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients <b>(3)</b>	Total Billed O/P Charges (Gross) for Health Care Program Patients <b>(4)</b>		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) <b>(6)</b>	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) <b>(7)</b>
1.	Operating Room	0.291243	1,034,366			301,252		
2.	Recovery Room							
3.	Delivery and Labor Room	0.553646	2,654,936			1,469,895		
4.	Anesthesiology	0.028580	272,639			7,792		
5.	Radiology - Diagnostic	0.149314	837,027			124,980		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	0.150942	1,424,028			214,946		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.214286	431,699			92,507		
13.	Physical Therapy	0.281286	52,668			14,815		
14.	Occupational Therapy	0.247111	23,797			5,881		
15.	Speech Pathology	0.524300	1,720			902		
16.	EKG	0.108572	139,148			15,108		
17.	EEG	0.095518	4,642			443		
18.	Med. / Surg. Supplies	0.774432	329,394			255,093		
19.	Drugs Charged to Patients	0.384072	928,833			356,739		
20.	Renal Dialysis	0.280374						
21.	Ambulance							
22.	Audiology	0.474815						
23.	EKG and EEG							
23.01	Cardiopulmonary	1.269873						
23.02	Cardiac Cath Lab	0.165340	34,098			5,638		
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	0.276645	368,583			101,967		
26.	Observation	0.556959						
27.	<b>Total</b>		8,537,578			2,967,958		

\* 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: 14-0289	Medicaid Provider Number: 13047
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

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)	\$ 473.66	\$ 776.35	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,735			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 1,295,460	\$	\$	\$
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)	\$ 1,295,460	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 3,215.33	21	\$ 67,522
9.	Coronary Care Unit	\$		\$
10.	Other	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 360.00	1,327	\$ 477,720
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 2,967,958
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 4,808,660</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> 14-0289		<b>Medicaid Provider Number:</b> 13047	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 01-01-07 To: 12-31-07	

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.	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>14-0289</b>	Medicaid Provider Number: <b>13047</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01-01-07</b> To: <b>12-31-07</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	130,918	32,995,043	0.003968	1,424,028			5,651		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	131,210	6,251,548	0.020988	139,148			2,920		
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Audiology									
23.	EKG and EEG									
23.01	Cardiopulmonary									
23.02	Cardiac Cath Lab									
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.	Rehabilitation Unit									
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>							8,571		

\* 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**

<b>Medicare Provider Number:</b> 14-0289	<b>Medicaid Provider Number:</b> 13047
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-07 To: 12-31-07

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)	4,808,660		
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)	8,571		
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>	4,817,231		
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)	8,537,578
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	686,331
	B. Rehabilitation Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	138,900
	F. Coronary Care Unit	
	G. Other	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	868,903
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	10,231,712
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	5,414,481
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**

<b>Medicare Provider Number:</b> 14-0289	<b>Medicaid Provider Number:</b> 13047
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-07 To: 12-31-07

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)	4,817,231		
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)	4,817,231		
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>	4,817,231		

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: 14-0289	Medicaid Provider Number: 13047
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

**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)	5,414,481
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: 14-0289	Medicaid Provider Number: 13047
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

**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**

	Adults and Pediatrics	Sub I Rehabilitation Ur	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> 14-0289	<b>Medicaid Provider Number:</b> 13047	
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-07	<b>To:</b> 12-31-07

**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	10,904,541	37,441,340	0.291243
2.	Recovery Room			
3.	Delivery and Labor Room	4,332,055	7,824,592	0.553646
4.	Anesthesiology	179,484	6,280,144	0.028580
5.	Radiology - Diagnostic	8,726,218	58,442,242	0.149314
6.	Radiology - Therapeutic			
7.	Nuclear Medicine			
8.	Laboratory	4,980,354	32,995,043	0.150942
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,231,043	10,411,519	0.214286
13.	Physical Therapy	1,865,400	6,631,693	0.281286
14.	Occupational Therapy	807,198	3,266,544	0.247111
15.	Speech Pathology	444,119	847,070	0.524300
16.	EKG	678,744	6,251,548	0.108572
17.	EEG	85,491	895,021	0.095518
18.	Med. / Surg. Supplies	12,626,144	16,303,758	0.774432
19.	Drugs Charged to Patients	5,451,088	14,192,896	0.384072
20.	Renal Dialysis	160,824	573,606	0.280374
21.	Ambulance			
22.	Audiology	156,140	328,844	0.474815
23.	EKG and EEG			
23.01	Cardiopulmonary	656,485	516,969	1.269873
23.02	Cardiac Cath Lab	645,210	3,902,329	0.165340
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	6,842,186	24,732,742	0.276645
26.	Observation	628,073	1,127,682	0.556959
<b>Routine Service Cost Centers</b>				
27.	Adults and Pediatrics	12,372,960	26,122	473.66
28.	Rehabilitation Unit	2,687,707	3,462	776.35
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	2,122,115	660	3,215.33
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	1,371,258	3,809	360.00

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

PRELIMINARY

Medicare Provider Number: 14-0289	Medicaid Provider Number: 13047
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-07 To: 12-31-07

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,756		2,756
Newborn Days	1,327		1,327
Total Inpatient Revenue	10,231,712		10,231,712
Ancillary Revenue	8,537,578		8,537,578
Routine Revenue	1,694,134		1,694,134
Inpatient Received and Receivable			
<b>Organized Outpatient Clinic Reconciliation</b>			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
<b>Referred Outpatient and ER Reconciliation</b>			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

**Notes:**

Rehab Unit opened 01/01/2005.

Adjusted Total Hospital Adults & Peds Days to agree with W/S S-3 (24,796).