

# 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: Rockford Memorial Hospital		Medicare Provider Number: 14-0239	
Street: 2400 N. Rockton Avenue		Medicaid Provider Number: 18005	
City: Rockford	State: Illinois	Zip: 61103	
Period Covered by Statement:	From: 01/01/2007	To: 12/31/2007	

## 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	<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	<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	<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)) Rockford Memorial Hospital 18005 for the cost report beginning 01/01/2007 and ending 12/31/2007; 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)  
 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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	218	80,103		51,612	64.43%		12,342	5.73	
2.	Psychiatric Unit	12	4,380		2,717	62.03%		650	4.18	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	22	8,030		5,106	63.59%				
6.	Coronary Care Unit									
7.	Neonatal ICU	40	14,600		12,831	87.88%				
8.	Pediatric ICU	7	2,555		1,182	46.26%				
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	21	7,665		3,878	50.59%				
16.	Total	320	117,333		77,326	65.90%		12,992	5.65	
17.	Observation Bed Days				3,362					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				10,760			3,543	5.53	
2.	Psychiatric Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				120					
6.	Coronary Care Unit									
7.	Neonatal ICU				8,417					
8.	Pediatric ICU				289					
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				2,356					
16.	Total				21,942	28.38%		3,543	5.53	

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>14-0239</b>	Medicaid Provider Number: <b>18005</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01/01/2007</b> To: <b>12/31/2007</b>

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	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.385262	5,925,154			2,282,737		
2.	Recovery Room	0.437778	342,168			149,794		
3.	Delivery and Labor Room	0.662371	3,997,022			2,647,511		
4.	Anesthesiology	0.482864	606,197			292,711		
5.	Radiology - Diagnostic	0.300554	2,681,416			805,910		
6.	Radiology - Therapeutic	0.400681	24,316			9,743		
7.	Nuclear Medicine	0.286192	143,129			40,962		
8.	Laboratory	0.251086	7,516,995			1,887,412		
9.	Blood							
10.	Blood - Administration	0.410252	849,420			348,476		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.198150	8,836,556			1,750,964		
13.	Physical Therapy	0.682185	230,415			157,186		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.128374	936,930			120,277		
17.	EEG	0.208277	157,451			32,793		
18.	Med. / Surg. Supplies	0.137242	4,720,953			647,913		
19.	Drugs Charged to Patients	0.281396	13,207,619			3,716,571		
20.	Renal Dialysis	0.572399	98,751			56,525		
21.	Ambulance	0.696365						
22.	G.I. Lab	0.306510	147,699			45,271		
23.	MRI	0.113812	445,489			50,702		
23.01	CT Scan	0.073536	1,822,054			133,987		
23.02	Cardiac Cath	0.280335	950,425			266,437		
23.03	Womens Health Advantage	4.217077						
23.04	Outpatient Detox							
23.05	Special Surgical Services	0.453274	439			199		
23.06	Genetic Services	1.516864	31,001			47,024		
23.07	Child Psychiatry	2.870379	1,668			4,788		
23.08	Pain Center	0.232548	4,798			1,116		
23.09	Antenatal Center	0.247470	376,652			93,210		
<b>Outpatient Service Cost Centers</b>								
24.	Child Psychiatric Clinic							
25.	Emergency	0.378485	1,921,391			727,218		
26.	Observation	1.002008						
27.	<b>Total</b>		55,976,108			16,317,437		

\* 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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 908.71	\$ 918.30	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,760			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 9,777,720	\$	\$	\$
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)	\$ 9,777,720	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 2,032.70	120	\$ 243,924
9.	Coronary Care Unit	\$		\$
10.	Neonatal ICU	\$ 1,007.69	8,417	\$ 8,481,727
11.	Pediatric ICU	\$ 1,969.40	289	\$ 569,157
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 696.43	2,356	\$ 1,640,789
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 16,317,437
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 37,030,754</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> 14-0239	<b>Medicaid Provider Number:</b> 18005
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/2007 To: 12/31/2007

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.	Psychiatric Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
9.	Pediatric ICU						
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.	Child Psychiatric 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>14-0239</b>	Medicaid Provider Number: <b>18005</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01/01/2007</b> To: <b>12/31/2007</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.	G.I. Lab									
23.	MRI									
23.01	CT Scan									
23.02	Cardiac Cath									
23.03	Womens Health Advantage									
23.04	Outpatient Detox									
23.05	Special Surgical Services									
23.06	Genetic Services									
23.07	Child Psychiatry									
23.08	Pain Center									
23.09	Antenatal Center									
<b>Outpatient Ancillary Cost Centers</b>										
24.	Child Psychiatric 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.	Psychiatric Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU									
34.	Pediatric ICU									
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**

<b>Medicare Provider Number:</b> 14-0239		<b>Medicaid Provider Number:</b> 18005		
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 01/01/2007 To: 12/31/2007		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	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)	37,030,754		
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>	37,030,754		
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)	55,976,108
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	10,205,443
	B. Psychiatric Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	1,690,635
	F. Coronary Care Unit	
	G. Neonatal ICU	24,096,881
	H. Pediatric ICU	2,334,553
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	2,238,410
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	96,542,030
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	59,511,276
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> 14-0239	<b>Medicaid Provider Number:</b> 18005
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01/01/2007 To: 12/31/2007

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)	37,030,754		
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)	37,030,754		
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>	37,030,754		

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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

**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)	59,511,276
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 (4)	Sum of Columns 1 - 4 (5)
		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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
			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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

**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 Psychiatric Unit	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 Psychiatric Unit	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 Psychiatric Unit	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

Medicare Provider Number: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	34,668,209	89,985,997	0.385262
2.	Recovery Room	2,106,712	4,812,283	0.437778
3.	Delivery and Labor Room	5,693,849	8,596,164	0.662371
4.	Anesthesiology	3,689,251	7,640,346	0.482864
5.	Radiology - Diagnostic	9,850,760	32,775,288	0.300554
6.	Radiology - Therapeutic	2,779,639	6,937,290	0.400681
7.	Nuclear Medicine	1,117,091	3,903,290	0.286192
8.	Laboratory	12,051,998	47,999,402	0.251086
9.	Blood			
10.	Blood - Administration	2,434,351	5,933,798	0.410252
11.	Intravenous Therapy			
12.	Respiratory Therapy	7,918,726	39,963,379	0.198150
13.	Physical Therapy	2,250,633	3,299,154	0.682185
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	2,693,124	20,978,789	0.128374
17.	EEG	235,894	1,132,597	0.208277
18.	Med. / Surg. Supplies	5,266,122	38,371,127	0.137242
19.	Drugs Charged to Patients	18,267,459	64,917,167	0.281396
20.	Renal Dialysis	798,499	1,395,004	0.572399
21.	Ambulance	3,764,525	5,405,969	0.696365
22.	G.I. Lab	2,246,676	7,329,859	0.306510
23.	MRI	1,947,022	17,107,313	0.113812
23.01	CT Scan	2,243,517	30,508,928	0.073536
23.02	Cardiac Cath	8,728,022	31,134,297	0.280335
23.03	Womens Health Advantage	78,231	18,551	4.217077
23.04	Outpatient Detox			
23.05	Special Surgical Services	783,206	1,727,888	0.453274
23.06	Genetic Services	1,007,976	664,513	1.516864
23.07	Child Psychiatry	1,043,707	363,613	2.870379
23.08	Pain Center	2,336,206	10,046,118	0.232548
23.09	Antenatal Center	1,025,666	4,144,615	0.247470
<b>Outpatient Ancillary Centers</b>				
24.	Child Psychiatric Clinic			
25.	Emergency	13,397,358	35,397,345	0.378485
26.	Observation	3,057,470	3,051,344	1.002008
<b>Routine Service Cost Centers</b>				
			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	49,955,257	54,974	908.71
28.	Psychiatric Unit	2,495,012	2,717	918.30
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	10,378,956	5,106	2,032.70
32.	Coronary Care Unit			
33.	Neonatal ICU	12,929,708	12,831	1,007.69
34.	Pediatric ICU	2,327,833	1,182	1,969.40
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	2,700,741	3,878	696.43

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

PRELIMINARY

Medicare Provider Number: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2007 To: 12/31/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	19,586		19,586
Newborn Days	2,356		2,356
Total Inpatient Revenue	96,542,030		96,542,030
Ancillary Revenue	55,976,108		55,976,108
Routine Revenue	40,565,922		40,565,922
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:**

BHF Supplement 2 charges match the Medicare W/S C charges.

Nursery Beds and Bed Days Available were taken from the prior year cost report.