

# Hospital Statement of Cost

Illinois Department of Public Aid, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

**General Information**

**PRELIMINARY**

Name of Hospital: St. Elizabeth's Hospital		Medicare Provider Number: 14-0187	
Street: 211 South Third Street		Public Aid Provider Number: 2002	
City: Belleville	State: Illinois	Zip: 62220	
Period Covered by Statement:	From: 07/01/2006	To: 06/30/2007	

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> 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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Rehabilitation	<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)) St. Elizabeth's Hospital 2002 for the cost report beginning 07/01/2006 and ending 06/30/2007; 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)  
 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 Public Aid 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: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of 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	176	64,240		41,785	65.05%		10,687	4.52	
2.	Rehabilitation Unit	30	10,950		7,886	72.02%		616	12.80	
3.	Psychiatric Unit	30	10,950		6,423	58.66%		1,372	4.68	
4.	Sub III									
5.	Intensive Care Unit	24	8,760		6,488	74.06%				
6.	Coronary Care Unit									
7.	Neonatal ICU									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	30	10,950		3,338	30.48%				
16.	Total	290	105,850		65,920	62.28%		12,675	4.94	
17.	Observation Bed Days				1,318					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics									
2.	Rehabilitation Unit				492			41	12.00	
3.	Psychiatric Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Neonatal ICU									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				492	0.75%		41	12.00	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

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

PRELIMINARY

Medicare Provider Number: <b>14-0187</b>	Public Aid Provider Number: <b>2002</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>07/01/2006</b> To: <b>06/30/2007</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	0.329762	4,201			1,385		
2.	Recovery Room	0.227939	100			23		
3.	Delivery and Labor Room	0.523992						
4.	Anesthesiology	0.124157	188			23		
5.	Radiology - Diagnostic	0.260277	8,453			2,200		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.267107	3,502			935		
8.	Laboratory	0.197605	55,647			10,996		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.293843	20,418			6,000		
13.	Physical Therapy	0.391503	200,154			78,361		
14.	Occupational Therapy	0.167730	178,222			29,893		
15.	Speech Pathology	0.147400	74,944			11,047		
16.	EKG	0.122133	6,519			796		
17.	EEG							
18.	Med. / Surg. Supplies	0.382864	75,602			28,945		
19.	Drugs Charged to Patients	0.174975	74,579			13,049		
20.	Renal Dialysis	0.232633	17,402			4,048		
21.	Ambulance	0.980591						
22.	Cat Scan	0.076256	4,221			322		
23.	Cardiac Cath Lab	0.207841						
23.01	Pulmonary Testing	0.130736						
23.02	Sleep Lab	0.267186						
23.03	Vascular Lab	0.192955						
23.04	Other O/P Services	0.193475						
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	0.275080						
26.	Observation	0.655528	3,008			1,972		
27.	<b>Total</b>		727,160			189,995		

\* 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: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

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

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Psychiatric Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 672.19	\$ 586.42	\$ 653.78	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		492		
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$	\$ 288,519	\$	\$
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)	\$	\$ 288,519	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,354.09		\$
9.	Coronary Care Unit	\$		\$
10.	Neonatal ICU	\$		\$
11.	Other	\$		\$
12.	Other	\$		\$
13.	Other	\$		\$
14.	Other	\$		\$
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 428.15		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 189,995
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 478,514</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> 14-0187	<b>Public Aid Provider Number:</b> 2002
<b>Program:</b> Medicaid-Rehabilitation	<b>Period Covered by Statement:</b> From: 07/01/2006 To: 06/30/2007

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.	Psychiatric Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
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>14-0187</b>	Public Aid Provider Number: <b>2002</b>
Program: <b>Medicaid-Rehabilitation</b>	Period Covered by Statement: From: <b>07/01/2006</b> To: <b>06/30/2007</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.	Cat Scan									
23.	Cardiac Cath Lab									
23.01	Pulmonary Testing									
23.02	Sleep Lab									
23.03	Vascular Lab									
23.04	Other O/P Services									
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.	Psychiatric Unit									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Neonatal ICU									
34.	Other									
35.	Other									
35.01	Other									
35.02	Other									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	<b>Total</b>									

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

**Hospital Statement of Cost  
Computation of Lesser of Reasonable Cost or Customary Charges**

**PRELIMINARY**

Medicare Provider Number: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

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)	478,514		
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>	478,514		
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)	727,160
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	
	B. Rehabilitation Unit	393,636
	C. Psychiatric Unit	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Neonatal ICU	
	H. Other	
	I. Other	
	J. Other	
	K. Other	
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	1,120,796
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	642,282
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: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

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)	478,514		
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)	478,514		
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>	478,514		

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: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

**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)	642,282
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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)	Ratio	Amount (Col. 1x4A) (4B)
			(2A)	(2B)	(3A)	(3B)	(4A)	(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: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

**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 Unit	Sub II Psychiatric Unit	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 Unit	Sub II Psychiatric Unit	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 Unit	Sub II Psychiatric Unit	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> 14-0187	<b>Public Aid Provider Number:</b> 2002
<b>Program:</b> Medicaid-Rehabilitation	<b>Period Covered by Statement:</b> From: 07/01/2006 To: 06/30/2007

**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)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	12,081,338	36,636,520	0.329762
2.	Recovery Room	1,772,253	7,775,118	0.227939
3.	Delivery and Labor Room	2,620,886	5,001,771	0.523992
4.	Anesthesiology	649,592	5,232,027	0.124157
5.	Radiology - Diagnostic	9,825,972	37,751,971	0.260277
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	1,378,366	5,160,360	0.267107
8.	Laboratory	8,471,756	42,872,189	0.197605
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	2,432,238	8,277,335	0.293843
13.	Physical Therapy	5,740,055	14,661,569	0.391503
14.	Occupational Therapy	787,180	4,693,135	0.167730
15.	Speech Pathology	345,282	2,342,482	0.147400
16.	EKG	1,532,347	12,546,593	0.122133
17.	EEG			
18.	Med. / Surg. Supplies	18,705,436	48,856,613	0.382864
19.	Drugs Charged to Patients	7,889,884	45,091,546	0.174975
20.	Renal Dialysis	423,598	1,820,882	0.232633
21.	Ambulance	18,996	19,372	0.980591
22.	Cat Scan	2,715,334	35,608,347	0.076256
23.	Cardiac Cath Lab	4,055,813	19,514,060	0.207841
23.01	Pulmonary Testing	676,473	5,174,359	0.130736
23.02	Sleep Lab	898,232	3,361,828	0.267186
23.03	Vascular Lab	610,205	3,162,423	0.192955
23.04	Other O/P Services	217,175	1,122,494	0.193475
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
<b>Outpatient Ancillary Centers</b>				
24.	Clinic	3,719,124		
25.	Emergency	8,075,129	29,355,531	0.275080
26.	Observation	817,002	1,246,327	0.655528
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	28,973,456	43,103	672.19
28.	Rehabilitation Unit	4,624,532	7,886	586.42
29.	Psychiatric Unit	4,199,240	6,423	653.78
30.	Sub III			
31.	Intensive Care Unit	8,785,332	6,488	1,354.09
32.	Coronary Care Unit			
33.	Neonatal ICU			
34.	Other			
35.	Other			
35.01	Other			
35.02	Other			
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,429,169	3,338	428.15

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

PRELIMINARY

Medicare Provider Number: 14-0187	Public Aid Provider Number: 2002
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	492		492
Newborn Days			
Total Inpatient Revenue	727,160	393,636	1,120,796
Ancillary Revenue	727,160		727,160
Routine Revenue		393,636	393,636
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:**

Included Observation Bed Days from W/S S-3, Column 6.

The filed Medicaid Cost Report is the same as the IPCR of 11/02/2007. However, this filed report does not include the Nursery (DRG 391) Days.

Adjusted Medicaid Discharges to match W/S S-3 Col. 14.

Routine Charges came from Mick Welscher, consultant. These charges match the Paid Claims Report.--DW 01/14/2008