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: CGH Medical Center		**Medicare Provider Number:** 14-0043
Street: 100 East LeFevre Road		**Medicaid Provider Number:** 19010
City: Sterling	**State:** Illinois	**Zip:** 61081-1279
Period Covered by Statement:	**From:** 05-01-2006	**To:** 04-30-2007

Type of Control

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

Type of Hospital

[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]	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)) CGH Medical Center 19010 for the cost report beginning 05-01-2006 and ending 04-30-200 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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	83	30,295		14,293	47.18%		5,175	3.23	
2.	Sub I									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	13	4,745		2,403	50.64%				
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				1,178					
16.	Total	96	35,040		17,874	51.01%		5,175	3.23	
17.	Observation Bed Days				1,951					

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				2,363			1,045	2.38	
2.	Sub I									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				120					
6.	Coronary Care Unit									
7.	Other									
8.	Other									
9.	Other									
10.	Other									
11.	Other									
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				201					
16.	**Total**				2,684	15.02%		1,045	2.38	

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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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	0.363575	887,294			322,598		
2.	Recovery Room	0.424724	81,530			34,628		
3.	Delivery and Labor Room							
4.	Anesthesiology	0.298456	549,226			163,920		
5.	Radiology - Diagnostic	0.397717	172,239			68,502		
6.	Radiology - Therapeutic	0.082718						
7.	Nuclear Medicine	0.288018	66,604			19,183		
8.	Laboratory	0.192626	1,227,527			236,454		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	0.043457	191,710			8,331		
12.	Respiratory Therapy	0.512330	180,237			92,341		
13.	Physical Therapy	0.772740	21,260			16,428		
14.	Occupational Therapy	0.721028	3,197			2,305		
15.	Speech Pathology	1.800058	1,730			3,114		
16.	EKG	0.316917	489,583			155,157		
17.	EEG	0.310809	11,137			3,461		
18.	Med. / Surg. Supplies	0.288371	231,729			66,824		
19.	Drugs Charged to Patients	0.385787	838,677			323,551		
20.	Renal Dialysis	0.504761	9,000			4,543		
21.	Ambulance	1.345526						
22.	Pain Management	0.169029	460			78		
23.	Ultrasound	0.166605	63,240			10,536		
23.01	CT Scan	0.093070	469,764			43,721		
23.02	MRI	0.161047	114,974			18,516		
23.03	GI Lab	0.332985	33,558			11,174		
23.04	Diabetic Education	1.945536						
23.05	Other							
23.06	Other							
23.07	Other							
23.08	Other							
23.09	Other							
	Outpatient Service Cost Centers							
24.	Clinic							
25.	Emergency	0.246399	577,179			142,216		
26.	Observation	1.055886						
27.	**Total**		6,221,855			1,747,581		

* 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:		
14-0043	19010		
Program:	Period Covered by Statement:		
Medicaid-Hospital	From: 05-01-2006	To:	04-30-2007

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

Line No.	Description	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	$ 1,086.46	$	$	$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,363			
3.	Program general inpatient routine cost (Line 1 X Line 2)	$ 2,567,305	$	$	$
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)	$ 2,567,305	$	$	$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	$ 1,684.83	120	$ 202,180
9.	Coronary Care Unit	$		$
10.	Other	$		$
11.	Other	$		$
12.	Other	$		$
13.	Other	$		$
14.	Other	$		$
15.	Other	$		$
15.01	Other	$		$
15.02	Other	$		$
16.	Nursery	$	201	$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			$ 1,747,581
18.	**Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)**			$ **4,517,066**

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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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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.	Sub I						
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
		(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)**										

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Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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.	Pain Management									
23.	Ultrasound									
23.01	CT Scan									
23.02	MRI									
23.03	GI Lab									
23.04	Diabetic Education									
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.	Sub I									
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.	**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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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)	4,517,066		
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)**	4,517,066		
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)	6,221,855
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	3,183,517
	B. Sub I	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	316,166
	F. Coronary Care Unit	
	G. Other	
	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.	**Total Charges for Patient Services (Sum of Lines 8 through 10)**	9,721,538
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	5,204,472
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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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)	4,517,066		
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)	4,517,066		
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)**	4,517,066		

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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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)	5,204,472
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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** Sub I	**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** Sub I	**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** Sub I	**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 **BHF Supplement No. 2**
Graduate Medical Education Cost Adjustment Sheet
PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

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	8,446,079	23,230,633	0.363575
2.	Recovery Room	607,171	1,429,566	0.424724
3.	Delivery and Labor Room			
4.	Anesthesiology	1,861,463	6,236,970	0.298456
5.	Radiology - Diagnostic	3,398,701	8,545,536	0.397717
6.	Radiology - Therapeutic	1,500	18,134	0.082718
7.	Nuclear Medicine	1,131,957	3,930,157	0.288018
8.	Laboratory	6,174,108	32,052,312	0.192626
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy	80,785	1,858,965	0.043457
12.	Respiratory Therapy	1,611,930	3,146,274	0.512330
13.	Physical Therapy	943,240	1,220,644	0.772740
14.	Occupational Therapy	188,409	261,306	0.721028
15.	Speech Pathology	310,240	172,350	1.800058
16.	EKG	5,876,643	18,543,175	0.316917
17.	EEG	391,512	1,259,655	0.310809
18.	Med. / Surg. Supplies	751,917	2,607,460	0.288371
19.	Drugs Charged to Patients	4,446,576	11,525,977	0.385787
20.	Renal Dialysis	59,057	117,000	0.504761
21.	Ambulance	3,221,860	2,394,498	1.345526
22.	Pain Management	267,459	1,582,329	0.169029
23.	Ultrasound	475,720	2,855,383	0.166605
23.01	CT Scan	1,786,664	19,196,945	0.093070
23.02	MRI	1,187,270	7,372,203	0.161047
23.03	GI Lab	2,168,356	6,511,881	0.332985
23.04	Diabetic Education	187,503	96,376	1.945536
23.05	Other			
23.06	Other			
23.07	Other			
23.08	Other			
23.09	Other			
	Outpatient Ancillary Centers			
24.	Clinic			
25.	Emergency	5,518,634	22,397,113	0.246399
26.	Observation	2,119,683	2,007,493	1.055886
	Routine Service Cost Centers		**Total Days**	**Per Diem**
27.	Adults and Pediatrics	17,648,420	16,244	1,086.46
28.	Sub I			
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	4,048,637	2,403	1,684.83
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		1,178	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0043	19010
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 05-01-2006 To: 04-30-2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,483		2,483
Newborn Days	201		201
Total Inpatient Revenue	9,721,538		9,721,538
Ancillary Revenue	6,221,855		6,221,855
Routine Revenue	3,499,683		3,499,683
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:

Type of Control per W/S S-2 = 12 = Governmental, City. Governmental, City is consistent with the FYE 04-30-04, 05, 06 reports.

Adjusted Costs & Charges from Medicare Report to agree with W/S B, Part I, Column 25, and W/S C, Column 8.