

# Hospital Statement of Cost

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

**General Information**

**PRELIMINARY**

Name of Hospital: Clarian Health Partners, Inc.		Medicare Provider Number: 15-0056	
Street: I-65 at 21st Street		Public Aid Provider Number: 9024	
City: Indianapolis	State: Indiana	Zip: 46202	
Period Covered by Statement:	From: 01-01-02	To: 12-31-02	

**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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<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)) Clarian Health Partners, Inc. 9024 for the cost report beginning 01-01-02 and ending 12-31-02 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: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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	1,029	359,160		258,943	72.10%		53,184	5.96	
2.	Behavioral Care Center	46	16,790		9,473	56.42%		1,180	8.03	
3.										
4.										
5.	Intensive Care Unit	59	21,535		17,295	80.31%				
6.	Coronary Care Unit	45	16,425		11,684	71.14%				
7.	Newborn ICU	35	12,775		8,248	64.56%				
8.	Burn ICU	6	2,190		1,517	69.27%				
9.	UH Surg 6IC	29	10,585		6,597	62.32%				
10.	UH NS 3IC	9	3,285		2,285	69.56%				
11.	RH Ped IC	34	12,410		8,940	72.04%				
12.	Pediatric Cancer Center	6	2,190		1,666	76.07%				
13.										
14.										
15.	Newborn Nursery	45	16,425		8,602	52.37%				
16.	Total	1,343	473,770		335,250	70.76%		54,364	6.01	
17.	Observation Bed Days				17,468					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				430					
2.	Behavioral Care Center									
3.										
4.										
5.	Intensive Care Unit				112					
6.	Coronary Care Unit				9					
7.	Newborn ICU									
8.	Burn ICU				62					
9.	UH Surg 6IC				25					
10.	UH NS 3IC				32					
11.	RH Ped IC				52					
12.	Pediatric Cancer Center				31					
13.										
14.										
15.	Newborn Nursery									
16.	Total				753	0.22%				

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:	15-0056	Public Aid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-02 To: 12-31-02

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	0.411378	441,685			181,699		
2.	Recovery Room	0.553946	20,814			11,530		
3.	Delivery and Labor Room	0.661227	3,600			2,380		
4.	Anesthesiology	0.637180	18,877			12,028		
5.	Radiology - Diagnostic	0.319105	237,530			75,797		
6.	Radiology - Therapeutic	0.455654	3,828			1,744		
7.	Radioisotope	0.491657	5,132			2,523		
8.	Laboratory	0.350755	214,909			75,380		
9.								
10.	Blood - Administration	0.681812	29,752			20,285		
11.								
12.	Respiratory Therapy	0.438714	181,628			79,683		
13.	Physical Therapy	0.772908	15,492			11,974		
14.	Occupational Therapy	0.844430	14,670			12,388		
15.	Speech Pathology	1.065417	8,678			9,246		
16.	EKG	0.257047	3,124			803		
17.	EEG	0.726959	3,231			2,349		
18.	Med. / Surg. Supplies	0.631108						
19.	Drugs Charged to Patients	0.512578						
20.	Renal Dialysis	0.712497	8,951			6,378		
21.	Ambulance and Neonatal Ambulance	0.618345	30,049			18,581		
22.	Endoscopy Unit	0.436427	1,976			862		
23.	Pulmonary Function	0.609214	4,244			2,586		
23.01	Transplant Immunology	0.679239						
23.02	Bone Marrow Transplant Lab	1.126906						
23.03	O/P Psychology	0.887614						
23.04	Cardiac Catheterization	0.268412	16,715			4,487		
23.05	Day Surgery	1.677982	1,957			3,284		
23.06	Oncology	0.495732						
23.07								
23.08	RH NBN ECMO IC	1.496164						
23.09	Cardiology	0.462654	15,087			6,980		
<b>Outpatient Service Cost Centers</b>								
24.	"Clinics": Lines 60.01 through 60.25	2.237029	6,317			14,131		
25.	Emergency/ Admitting Rooms	0.542139	41,264			22,371		
26.	Observ Beds:Non-distinct & Distinct	0.933027						
27.	<b>Total</b>		1,329,510			579,469		

\* 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: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

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

Line No.	Description	Adults and Pediatrics	Sub I Behavioral Care Cente	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 732.93	\$ 928.42	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	430			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 315,160	\$	\$	\$
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 (OHF 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)	\$ 315,160	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,351.03	112	\$ 151,315
9.	Coronary Care Unit	\$ 1,445.04	9	\$ 13,005
10.	Newborn ICU	\$ 934.41		\$
11.	Burn ICU	\$ 1,452.75	62	\$ 90,071
12.	UH Surg 6IC	\$ 1,121.85	25	\$ 28,046
13.	UH NS 3IC	\$ 1,409.09	32	\$ 45,091
14.	RH Ped IC	\$ 1,351.71	52	\$ 70,289
15.	Pediatric Cancer Center	\$ 1,139.14	31	\$ 35,313
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 579,469
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 1,327,759</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> 15-0056	<b>Public Aid Provider Number:</b> 9024
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-02 To: 12-31-02

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 (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF 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.	Behavioral Care Center						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Newborn ICU						
9.	Burn ICU						
10.	UH Surg 6IC						
10.01	UH NS 3IC						
10.02	RH Ped IC						
10.03	Pediatric Cancer Center						
10.04							
10.05							
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.	"Clinics": Lines 60.01 through 60										
14.	Emergency/ Admitting Rooms										
15.	Observ Beds:Non-distinct & Disti										
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:	15-0056	Public Aid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-02 To: 12-31-02

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 (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF 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	442,688	237,618,022	0.001863	441,685			823		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	483,417	15,791,450	0.030613	18,877			578		
5.	Radiology - Diagnostic	25,000	187,303,094	0.000133	237,530			32		
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Laboratory	60,025	180,400,783	0.000333	214,909			72		
9.										
10.	Blood - Administration									
11.										
12.	Respiratory Therapy									
13.	Physical Therapy	202,956	10,954,737	0.018527	15,492			287		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	1,666,506	18,665,160	0.089284	3,124			279		
17.	EEG	42,586	4,721,438	0.009020	3,231			29		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	198,229	21,201,187	0.009350	8,951			84		
21.	Ambulance and Neonatal Ambulance									
22.	Endoscopy Unit									
23.	Pulmonary Function	50,000	9,285,344	0.005385	4,244			23		
23.01	Transplant Immunology	60,000	3,520,617	0.017042						
23.02	Bone Marrow Transplant Lab									
23.03	O/P Psychology									
23.04	Cardiac Catheterization	719,000	50,818,959	0.014148	16,715			236		
23.05	Day Surgery									
23.06	Oncology	237,500	4,079,935	0.058212						
23.07										
23.08	RH NBN ECMO IC									
23.09	Cardiology									
<b>Outpatient Ancillary Cost Centers</b>										
24.	"Clinics": Lines 60.01 through 60.25	465,128	19,055,868	0.024409	6,317			154		
25.	Emergency/ Admitting Rooms	2,611,419	49,306,755	0.052963	41,264			2,185		
26.	Observ Beds:Non-distinct & Distinct									
<b>Routine Service Cost Centers</b>			<b>Days</b>	<b>Per Diem</b>	<b>Days</b>					
27.	Adults and Pediatrics	912,499	276,411	3.30	430			1,419		
28.	Behavioral Care Center	305,000	9,473	32.20						
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit	25,000	11,684	2.14	9			19		
33.	Newborn ICU									
34.	Burn ICU									
35.	UH Surg 6IC									
35.01	UH NS 3IC									
35.02	RH Ped IC									
35.03	Pediatric Cancer Center									
35.04										
35.05										
36.	Nursery									
37.	<b>Total</b>							6,220		

\* 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> 15-0056		<b>Public Aid Provider Number:</b> 9024	
<b>Program:</b> Medicaid-Hospital		<b>Period Covered by Statement:</b> From: 01-01-02 To: 12-31-02	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	Organized Clinic (2) Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)		
2.	Inpatient Operating Services (OHF Page 4, Line 18)	1,327,759	
3.	Interns and Residents Not in an Approved Teaching Program (OHF Page 5, Line 17, Col. 6)		
4.	Hospital Based Physician Services (OHF Page 6, Line 37, Cols. 6 & 7)	6,220	
5.	Services of Teaching Physicians (OHF 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>	1,333,979	
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)	1,329,510
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	486,700
	B. Behavioral Care Center	
	C.	
	D.	
	E. Intensive Care Unit	113,193
	F. Coronary Care Unit	9,060
	G. Newborn ICU	
	H. Burn ICU	87,316
	I. UH Surg 6IC	23,556
	J. UH NS 3IC	30,804
	K. RH Ped IC	74,358
	L. Pediatric Cancer Center	44,080
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	<b>Total Charges for Patient Services (Sum of Lines 8 through 10)</b>	2,198,577
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	864,598
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: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	1,333,979		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,333,979		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (OHF 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>	1,333,979		

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: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

**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 (OHF Page 7, Line 12)	864,598
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 (OHF 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**

OHF Supplement No. 1

**PRELIMINARY**

<b>Medicare Provider Number:</b> 15-0056	<b>Public Aid Provider Number:</b> 9024
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-02 To: 12-31-02

**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 Behavioral Care	Sub II	Sub III
4. Program inpatient days (OHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (OHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (OHF page 2, Part III, Line 3)				

**Part C. Program Cost**

	General Service	Sub I Behavioral Care	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to OHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to OHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to OHF Page 7, Col. 3, Line 5)				

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I Behavioral Care	Sub II	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 OHF 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 OHF Page 4, Line 1)				

**Hospital Statement of Cost  
Graduate Medical Education Cost Adjustment Sheet**

OHF Supplement No. 2

**PRELIMINARY**

<b>Medicare Provider Number:</b> 15-0056	<b>Public Aid Provider Number:</b> 9024
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-02 To: 12-31-02

**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 OHF pgs. 3-4)
<b>Inpatient Ancillary Centers</b>				
1.	Operating Room	97,750,717	237,618,022	0.411378
2.	Recovery Room	14,546,279	26,259,377	0.553946
3.	Delivery and Labor Room	15,479,413	23,410,131	0.661227
4.	Anesthesiology	10,061,996	15,791,450	0.637180
5.	Radiology - Diagnostic	59,769,277	187,303,094	0.319105
6.	Radiology - Therapeutic	9,329,510	20,474,972	0.455654
7.	Radioisotope	6,342,673	12,900,604	0.491657
8.	Laboratory	63,276,404	180,400,783	0.350755
9.				
10.	Blood - Administration	19,009,882	27,881,397	0.681812
11.				
12.	Respiratory Therapy	27,454,289	62,579,062	0.438714
13.	Physical Therapy	8,467,005	10,954,737	0.772908
14.	Occupational Therapy	3,647,858	4,319,908	0.844430
15.	Speech Pathology	6,559,149	6,156,412	1.065417
16.	EKG	4,797,821	18,665,160	0.257047
17.	EEG	3,432,294	4,721,438	0.726959
18.	Med. / Surg. Supplies	67,155,210	106,408,444	0.631108
19.	Drugs Charged to Patients	78,603,383	153,349,115	0.512578
20.	Renal Dialysis	15,105,783	21,201,187	0.712497
21.	Ambulance and Neonatal Ambulance	7,824,030	12,653,178	0.618345
22.	Endoscopy Unit	2,202,140	5,045,834	0.436427
23.	Pulmonary Function	5,656,760	9,285,344	0.609214
23.01	Transplant Immunology	2,391,341	3,520,617	0.679239
23.02	Bone Marrow Transplant Lab	1,363,829	1,210,242	1.126906
23.03	O/P Psychology	266,223	299,931	0.887614
23.04	Cardiac Catheterization	13,640,416	50,818,959	0.268412
23.05	Day Surgery	6,898,633	4,111,268	1.677982
23.06	Oncology	2,022,556	4,079,935	0.495732
23.07				
23.08	RH NBN ECMO IC	1,029,696	688,224	1.496164
23.09	Cardiology	6,334,511	13,691,667	0.462654
<b>Outpatient Ancillary Centers</b>				
24.	"Clinics": Lines 60.01 through 60.25	42,628,536	19,055,868	2.237029
25.	Emergency/ Admitting Rooms	26,731,133	49,306,755	0.542139
26.	Observ Beds:Non-distinct & Distinct	13,872,573	14,868,359	0.933027
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	202,588,816	276,411	732.93
28.	Behavioral Care Center	8,794,912	9,473	928.42
29.				
30.				
31.	Intensive Care Unit	23,366,142	17,295	1,351.03
32.	Coronary Care Unit	16,883,823	11,684	1,445.04
33.	Newborn ICU	7,707,040	8,248	934.41
34.	Burn ICU	2,203,821	1,517	1,452.75
35.	UH Surg 6IC	7,400,860	6,597	1,121.85
35.01	UH NS 3IC	3,219,774	2,285	1,409.09
35.02	RH Ped IC	12,084,297	8,940	1,351.71
35.03	Pediatric Cancer Center	1,897,807	1,666	1,139.14
35.04				
35.05				
36.	Nursery		8,602	

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

PRELIMINARY

Medicare Provider Number: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-02 To: 12-31-02

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	753		753
Newborn Days			
Total Inpatient Revenue	2,198,577		2,198,577
Ancillary Revenue	1,329,510		1,329,510
Routine Revenue	869,067		869,067
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:**

Filed OHF Supplement No. 2 charges match the filed W/S C charges except for ER & Admitting Rooms and Non-distinct & Distinct Observation Rooms which have combined cost-to-charge ratios.

Reclassified Blood charges as Blood Administration. Blood is noncovered for Illinois Medicaid.