

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: 01-01-03	To: 12-31-03	

Type of Control

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

Type of Hospital

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

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital XXXX XXXX	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Clarian Health Partners, Inc. 9024 for the cost report beginning 01-01-03 and ending 12-31-03 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: 01-01-03 To: 12-31-03

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	1,037	378,505		257,663	68.07%		53,961	5.87	
2.	Behavioral Care Center	46	16,790		9,321	55.52%		1,035	9.01	
3.										
4.										
5.	Intensive Care Unit	59	21,535		17,259	80.14%				
6.	Coronary Care Unit	35	12,775		12,636	98.91%				
7.	Newborn ICU	35	12,775		9,185	71.90%				
8.	Burn ICU	6	2,190		1,529	69.82%				
9.	UH Surg 6IC	30	10,950		5,747	52.48%				
10.	UH NS 3IC	9	3,285		2,323	70.72%				
11.	RH Ped IC	34	12,410		8,872	71.49%				
12.	Pediatric Cancer Center	6	2,190		1,781	81.32%				
13.										
14.										
15.	Newborn Nursery	45	16,425		8,655	52.69%				
16.	Total	1,342	489,830		334,971	68.39%		54,996	5.93	
17.	Observation Bed Days				15,985					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				760					
2.	Behavioral Care Center									
3.										
4.										
5.	Intensive Care Unit				230					
6.	Coronary Care Unit				61					
7.	Newborn ICU									
8.	Burn ICU				1					
9.	UH Surg 6IC				41					
10.	UH NS 3IC				21					
11.	RH Ped IC				23					
12.	Pediatric Cancer Center				3					
13.										
14.										
15.	Newborn Nursery									
16.	Total				1,140	0.34%				

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: 01-01-03 To: 12-31-03

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	0.499223	792,419			395,594		
2.	Recovery Room	0.491150	31,951			15,693		
3.	Delivery and Labor Room	0.592664	43,684			25,890		
4.	Anesthesiology	0.808068	54,432			43,985		
5.	Radiology - Diagnostic	0.285380	242,208			69,121		
6.	Radiology - Therapeutic	0.397546	8,738			3,474		
7.	Radioisotope	0.484107	12,999			6,293		
8.	Nuclear Medicine/ Oncology	0.360990						
9.	Laboratory	0.304571	402,634			122,631		
10.	Blood - Administration	0.725953	80,496			58,436		
11.								
12.	Respiratory Therapy	0.361128	434,473			156,900		
13.	Physical Therapy	0.716499	21,021			15,062		
14.	Occupational Therapy	0.818517	7,189			5,884		
15.	Speech Pathology	0.882745	8,138			7,184		
16.	EKG	0.225104	21,526			4,846		
17.	EEG	0.617074	5,932			3,660		
18.	Med. / Surg. Supplies	0.202013	60,005			12,122		
19.	Drugs Charged to Patients	0.438757	553,416			242,815		
20.	Renal Dialysis	0.642362	42,935			27,580		
21.	Ambulance	0.525962						
22.	Endoscopy Unit	0.349254	3,416			1,193		
23.	Pulmonary Function	0.552294	3,310			1,828		
23.01	Transplant Immunology	0.413191						
23.02	Bone Marrow Transplant Lab	0.771482	5,301			4,090		
23.03	O/P Psychology	1.050972						
23.04	Cardiac Catheterization	0.175651	98,568			17,314		
23.05	Day Surgery	7.059925	155			1,094		
23.06	RH NBN ECMO IC	1.565017						
23.07	Cardiology	0.417578	18,079			7,549		
23.08	Admitting Rooms	0.501313	38,469			19,285		
23.09								
Outpatient Service Cost Centers								
24.	"Clinics": Lines 60.01 through 60.25	2.435617	14,159			34,486		
25.	Emergency	0.388263	26,287			10,206		
26.	Observ Beds:Non-distinct & Distinct	0.111697						
27.	Total		3,031,940			1,314,215		

* 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: 01-01-03 To: 12-31-03

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)	\$ 771.35	\$ 1,003.79	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	760			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 586,226	\$	\$	\$
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)	\$ 586,226	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,444.14	230	\$ 332,152
9.	Coronary Care Unit	\$ 1,405.77	61	\$ 85,752
10.	Newborn ICU	\$ 852.31		\$
11.	Burn ICU	\$ 1,530.59	1	\$ 1,531
12.	UH Surg 6IC	\$ 1,347.56	41	\$ 55,250
13.	UH NS 3IC	\$ 1,506.29	21	\$ 31,632
14.	RH Ped IC	\$ 1,570.63	23	\$ 36,124
15.	Pediatric Cancer Center	\$ 1,119.71	3	\$ 3,359
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,314,215
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,446,241

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program
PRELIMINARY**

Medicare Provider Number: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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										
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: 01-01-03 To: 12-31-03

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									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Radioisotope									
8.	Nuclear Medicine/ Oncology									
9.	Laboratory									
10.	Blood - Administration									
11.										
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.	Endoscopy Unit									
23.	Pulmonary Function									
23.01	Transplant Immunology									
23.02	Bone Marrow Transplant Lab									
23.03	O/P Psychology									
23.04	Cardiac Catheterization									
23.05	Day Surgery									
23.06	RH NBN ECMO IC									
23.07	Cardiology									
23.08	Admitting Rooms									
23.09										
Outpatient Ancillary Cost Centers										
24.	"Clinics": Lines 60.01 through 60.25									
25.	Emergency									
26.	Observ Beds:Non-distinct & Distinct									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Behavioral Care Center									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
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.	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: 15-0056		Public Aid Provider Number: 9024		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-03 To: 12-31-03		
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)	2,446,241		
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)			
5.	Services of Teaching Physicians (OHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	2,446,241		
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)	3,031,940
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	934,974
	B. Behavioral Care Center	
	C.	
	D.	
	E. Intensive Care Unit	243,175
	F. Coronary Care Unit	61,889
	G. Newborn ICU	
	H. Burn ICU	1,887
	I. UH Surg 6IC	41,866
	J. UH NS 3IC	21,843
	K. RH Ped IC	33,673
	L. Pediatric Cancer Center	4,428
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	4,375,675
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,929,434
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: 01-01-03 To: 12-31-03

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)	2,446,241		
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)	2,446,241		
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.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	2,446,241		

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.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)			

* 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: 01-01-03 To: 12-31-03

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 (OHF Page 7, Line 12)	1,929,434
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.	Total (Sum of Lines 1 - 3)							

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

OHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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

Medicare Provider Number: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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)
Inpatient Ancillary Centers				
1.	Operating Room	145,532,517	291,517,952	0.499223
2.	Recovery Room	15,431,100	31,418,294	0.491150
3.	Delivery and Labor Room	16,388,145	27,651,651	0.592664
4.	Anesthesiology	14,794,003	18,307,872	0.808068
5.	Radiology - Diagnostic	65,544,154	229,673,057	0.285380
6.	Radiology - Therapeutic	10,070,634	25,331,973	0.397546
7.	Radioisotope	6,516,611	13,461,089	0.484107
8.	Nuclear Medicine/ Oncology	2,170,148	6,011,657	0.360990
9.	Laboratory	69,653,804	228,694,969	0.304571
10.	Blood - Administration	18,886,684	26,016,403	0.725953
11.				
12.	Respiratory Therapy	29,281,137	81,082,529	0.361128
13.	Physical Therapy	9,217,990	12,865,317	0.716499
14.	Occupational Therapy	4,080,662	4,985,434	0.818517
15.	Speech Pathology	7,597,879	8,607,105	0.882745
16.	EKG	5,163,311	22,937,414	0.225104
17.	EEG	3,681,588	5,966,202	0.617074
18.	Med. / Surg. Supplies	24,056,659	119,084,964	0.202013
19.	Drugs Charged to Patients	78,330,524	178,528,235	0.438757
20.	Renal Dialysis	16,720,920	26,030,353	0.642362
21.	Ambulancence	8,782,256	16,697,516	0.525962
22.	Endoscopy Unit	2,271,710	6,504,460	0.349254
23.	Pulmonary Function	5,768,215	10,444,111	0.552294
23.01	Transplant Immunology	2,416,403	5,848,151	0.413191
23.02	Bone Marrow Transplant Lab	1,413,654	1,832,388	0.771482
23.03	O/P Psychology	295,385	281,059	1.050972
23.04	Cardiac Catheterization	12,156,600	69,208,865	0.175651
23.05	Day Surgery	6,774,104	959,515	7.059925
23.06	RH NBN ECMO IC	1,225,773	783,233	1.565017
23.07	Cardiology	6,610,045	15,829,503	0.417578
23.08	Admitting Rooms	6,877,658	13,719,283	0.501313
23.09				
Outpatient Ancillary Centers				
24.	"Clinics": Lines 60.01 through 60.25	47,228,756	19,390,880	2.435617
25.	Emergency	21,919,577	56,455,455	0.388263
26.	Observ Beds:Non-distinct & Distinct	1,398,574	12,521,154	0.111697
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	211,079,282	273,648	771.35
28.	Behavioral Care Center	9,356,293	9,321	1,003.79
29.				
30.				
31.	Intensive Care Unit	24,924,344	17,259	1,444.14
32.	Coronary Care Unit	17,763,288	12,636	1,405.77
33.	Newborn ICU	7,828,438	9,185	852.31
34.	Burn ICU	2,340,271	1,529	1,530.59
35.	UH Surg 6IC	7,744,428	5,747	1,347.56
35.01	UH NS 3IC	3,499,113	2,323	1,506.29
35.02	RH Ped IC	13,934,637	8,872	1,570.63
35.03	Pediatric Cancer Center	1,994,212	1,781	1,119.71
35.04				
35.05				
36.	Nursery		8,655	

**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: 01-01-03 To: 12-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,140		1,140
Newborn Days			
Total Inpatient Revenue	4,375,675		4,375,675
Ancillary Revenue	3,031,940		3,031,940
Routine Revenue	1,343,735		1,343,735
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:

Reclassified 13 Psych days and the related routine charges with Adults and Pediatrics.

Filed OHF Supplement No. 2 charges match the filed W/S C charges.

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

Kay Spears provided \$59,625 additional Medical Supplies and \$553,416 Drugs for Illinois Medicaid, 07-06-04.

Kay agreed that no professional fees are billed with Illinois Medicaid inpatient charges. Therefore, no professional components from W/S A-8-2, Column 4 are entered for our page 6.