

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: 01/01/04	To: 12/31/04	

Type of Control

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

Type of Hospital

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

Health Care Program

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

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

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Clarian Health Partners, Inc. 9024 for the cost report beginning 01/01/04 and ending 12/31/04 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: 01/01/04 To: 12/31/04

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	1,055	386,130		272,052	70.46%		55,031	6.05	
2.	Behavioral Care Center	46	16,836		10,299	61.17%		1,141	9.03	
3.										
4.										
5.	Intensive Care Unit	59	21,594		17,423	80.68%				
6.	Coronary Care Unit	47	17,202		12,961	75.35%				
7.	Newborn ICU	35	12,810		9,538	74.46%				
8.	Burn ICU	6	2,196		1,539	70.08%				
9.	UH Surg 6IC	18	6,588		6,034	91.59%				
10.	UH NS 3IC	9	3,294		2,687	81.57%				
11.	RH Ped IC	34	12,444		9,125	73.33%				
12.	Pediatric Cancer Center	6	2,196		1,817	82.74%				
13.										
14.										
15.	Newborn Nursery	45	16,470		8,552	51.92%				
16.	Total	1,360	497,760		352,027	70.72%		56,172	6.11	
17.	Observation Bed Days				13,648					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				1,135					
2.	Behavioral Care Center									
3.										
4.										
5.	Intensive Care Unit				64					
6.	Coronary Care Unit				61					
7.	Newborn ICU				60					
8.	Burn ICU				2					
9.	UH Surg 6IC				65					
10.	UH NS 3IC				16					
11.	RH Ped IC				64					
12.	Pediatric Cancer Center									
13.										
14.										
15.	Newborn Nursery									
16.	Total				1,467	0.42%				

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: 01/01/04 To: 12/31/04

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	0.434544	1,119,237			486,358		
2.	Recovery Room	0.484799	49,015			23,762		
3.	Delivery and Labor Room	0.514689	39,682			20,424		
4.	Anesthesiology	0.589942	63,493			37,457		
5.	Radiology - Diagnostic	0.235891	417,963			98,594		
6.	Radiology - Therapeutic	0.324465	1,352			439		
7.	Nuclear Medicine	0.382224	9,923			3,793		
8.	Laboratory	0.246582	655,968			161,750		
9.	Blood							
10.	Blood - Administration	0.615501	139,537			85,885		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.346669	711,160			246,537		
13.	Physical Therapy	0.610264	40,418			24,666		
14.	Occupational Therapy	0.659703	47,679			31,454		
15.	Speech Pathology	0.590029	13,790			8,136		
16.	EKG	0.160533	56,207			9,023		
17.	EEG	0.492832	12,538			6,179		
18.	Med. / Surg. Supplies	0.442251	110			49		
19.	Drugs Charged to Patients	0.423824						
20.	Renal Dialysis	0.479251	80,847			38,746		
21.	Ambulance	0.537459	4,805			2,582		
22.	Endoscopy Unit	0.286201	5,911			1,692		
23.	Pulmonary Function	0.526526	11,995			6,316		
23.01	Transplant Immunology	0.402268	5,879			2,365		
23.02	Bone Marrow Transplant Lab	0.498692	1,025			511		
23.03	RH NBN ECMO IC	0.804774						
23.04	Cardiology	0.209447	75,615			15,837		
23.05	Psych Other Ancillary	1.845207						
23.06	Cardiac Catheterization	0.259765	77,029			20,009		
23.07	Day Surgery	3.990660	514			2,051		
23.08	Oncology	0.449878						
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	2.357930	48,659			114,735		
Outpatient Service Cost Centers								
24.	"Clinics": Lines 60.01 through 60.25	1.364644	5,027			6,860		
25.	Emergency, ER Admitting	0.338924	72,189			24,467		
26.	Observ Beds:Non-distinct & Distinct	0.878185						
27.	Total		3,767,567			1,480,677		

* 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: 01/01/04 To: 12/31/04

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)	\$ 818.81	\$ 932.53	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	1,135			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 929,349	\$	\$	\$
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)	\$ 929,349	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,490.62	64	\$ 95,400
9.	Coronary Care Unit	\$ 1,547.22	61	\$ 94,380
10.	Newborn ICU	\$ 955.15	60	\$ 57,309
11.	Burn ICU	\$ 1,722.53	2	\$ 3,445
12.	UH Surg 6IC	\$ 1,454.81	65	\$ 94,563
13.	UH NS 3IC	\$ 1,460.95	16	\$ 23,375
14.	RH Ped IC	\$ 1,831.48	64	\$ 117,215
15.	Pediatric Cancer Center	\$ 1,313.68		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 35.66		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,480,677
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,895,713

**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: 01/01/04 To: 12/31/04

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, ER Admitting										
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: 01/01/04 To: 12/31/04

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	370,381	337,775,315	0.001097	1,119,237			1,228		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	1,184,650	20,290,898	0.058383	63,493			3,707		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	60,000	285,920,346	0.000210	655,968			138		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy	119,755	16,336,172	0.007331	40,418			296		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	791,411	33,063,159	0.023936	56,207			1,345		
17.	EEG	29,104	7,254,193	0.004012	12,538			50		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	221,250	32,294,778	0.006851	80,847			554		
21.	Ambulancence	163,746	18,784,910	0.008717	4,805			42		
22.	Endoscopy Unit									
23.	Pulmonary Function	50,000	10,610,830	0.004712	11,995			57		
23.01	Transplant Immunology	109,833	7,750,559	0.014171	5,879			83		
23.02	Bone Marrow Transplant Lab									
23.03	RH NBN ECMO IC									
23.04	Cardiology									
23.05	Psych Other Ancillary									
23.06	Cardiac Catheterization	1,571,085	39,208,904	0.040070	77,029			3,087		
23.07	Day Surgery									
23.08	Oncology	200,000	4,934,040	0.040535						
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr									
Outpatient Ancillary Cost Centers										
24.	"Clinics": Lines 60.01 through 60.25	856,530	35,458,397	0.024156	5,027			121		
25.	Emergency, ER Admitting	6,068,023	91,060,821	0.066637	72,189			4,810		
26.	Observ Beds:Non-distinct & Distinct									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	917,030	285,700	3.21	1,135			3,643		
28.	Behavioral Care Center	308,300	10,299	29.93						
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Newborn ICU	54,251	9,538	5.69	60			341		
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							19,502		

* 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: 01/01/04 To: 12/31/04

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			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)	2,895,713		
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)	19,502		
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)	2,915,215		
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)	3,767,567
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,217,350
	B. Behavioral Care Center	
	C.	
	D.	
	E. Intensive Care Unit	138,844
	F. Coronary Care Unit	129,276
	G. Newborn ICU	115,367
	H. Burn ICU	4,387
	I. UH Surg 6IC	139,833
	J. UH NS 3IC	32,802
	K. RH Ped IC	155,740
	L. Pediatric Cancer Center	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	5,701,166
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,785,951
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: 01/01/04 To: 12/31/04

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)	2,915,215		
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)	2,915,215		
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)	2,915,215		

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: 01/01/04 To: 12/31/04

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)	2,785,951
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 (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) (1)	Inpatient		Organized Clinic		Referred O / P	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)	Ratio (4A)	Amount (Col. 1x4A) (4B)
			(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
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: 01/01/04 To: 12/31/04

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: 01/01/04 To: 12/31/04

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	146,778,248	337,775,315	0.434544
2.	Recovery Room	17,548,351	36,197,163	0.484799
3.	Delivery and Labor Room	18,005,263	34,982,805	0.514689
4.	Anesthesiology	11,970,453	20,290,898	0.589942
5.	Radiology - Diagnostic	66,765,488	283,035,229	0.235891
6.	Radiology - Therapeutic	11,082,505	34,156,204	0.324465
7.	Nuclear Medicine	6,335,770	16,576,084	0.382224
8.	Laboratory	70,502,935	285,920,346	0.246582
9.	Blood			
10.	Blood - Administration	20,130,958	32,706,634	0.615501
11.	Intravenous Therapy			
12.	Respiratory Therapy	32,871,975	94,822,467	0.346669
13.	Physical Therapy	9,969,385	16,336,172	0.610264
14.	Occupational Therapy	3,797,130	5,755,814	0.659703
15.	Speech Pathology	5,241,681	8,883,762	0.590029
16.	EKG	5,307,728	33,063,159	0.160533
17.	EEG	3,575,102	7,254,193	0.492832
18.	Med. / Surg. Supplies	67,084,633	151,688,934	0.442251
19.	Drugs Charged to Patients	93,593,792	220,831,639	0.423824
20.	Renal Dialysis	15,477,311	32,294,778	0.479251
21.	Ambulancence	10,096,126	18,784,910	0.537459
22.	Endoscopy Unit	2,425,817	8,475,921	0.286201
23.	Pulmonary Function	5,586,881	10,610,830	0.526526
23.01	Transplant Immunology	3,117,798	7,750,559	0.402268
23.02	Bone Marrow Transplant Lab	1,658,885	3,326,472	0.498692
23.03	RH NBN ECMO IC	509,386	632,955	0.804774
23.04	Cardiology	7,704,635	36,785,655	0.209447
23.05	Psych Other Ancillary	1,414,757	766,720	1.845207
23.06	Cardiac Catheterization	10,185,115	39,208,904	0.259765
23.07	Day Surgery	8,805,503	2,206,528	3.990660
23.08	Oncology	2,219,715	4,934,040	0.449878
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	22,225,922	9,426,031	2.357930
Outpatient Ancillary Centers				
24.	"Clinics": Lines 60.01 through 60.25	48,388,075	35,458,397	1.364644
25.	Emergency, ER Admitting	30,862,673	91,060,821	0.338924
26.	Observ Beds:Non-distinct & Distinct	10,859,714	12,366,085	0.878185
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	233,932,961	285,700	818.81
28.	Behavioral Care Center	9,604,170	10,299	932.53
29.				
30.				
31.	Intensive Care Unit	25,971,065	17,423	1,490.62
32.	Coronary Care Unit	20,053,553	12,961	1,547.22
33.	Newborn ICU	9,110,229	9,538	955.15
34.	Burn ICU	2,650,967	1,539	1,722.53
35.	UH Surg 6IC	8,778,295	6,034	1,454.81
35.01	UH NS 3IC	3,925,574	2,687	1,460.95
35.02	RH Ped IC	16,712,249	9,125	1,831.48
35.03	Pediatric Cancer Center	2,386,955	1,817	1,313.68
35.04				
35.05				
36.	Nursery	304,954	8,552	35.66

**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: 01/01/04 To: 12/31/04

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,467		1,467
Newborn Days			
Total Inpatient Revenue	5,701,166		5,701,166
Ancillary Revenue	3,767,567		3,767,567
Routine Revenue	1,933,599		1,933,599
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 6 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.