

# 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: 01/01/05	To: 12/31/05	

**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 01/01/05 and ending 12/31/05 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: 01/01/05 To: 12/31/05

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	1,015	370,475		269,606	72.77%		55,319	5.95	
2.	Behavioral Care Center	49	17,885		8,242	46.08%		1,087	7.58	
3.										
4.										
5.	Intensive Care Unit	59	21,535		16,840	78.20%				
6.	Coronary Care Unit	80	29,200		12,714	43.54%				
7.	Newborn ICU	35	12,775		9,053	70.86%				
8.	Burn ICU	8	2,920		1,618	55.41%				
9.	UH Surg 6IC	18	6,570		5,818	88.55%				
10.	UH NS 3IC	9	3,285		2,702	82.25%				
11.	RH Ped IC	36	13,140		8,903	67.75%				
12.	Pediatric Cancer Center	6	2,190		1,746	79.73%				
13.										
14.										
15.	Newborn Nursery	45	16,470		1,340	8.14%				
16.	Total	1,360	496,445		338,582	68.20%		56,406	5.98	
17.	Observation Bed Days				14,707					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				860					
2.	Behavioral Care Center									
3.										
4.										
5.	Intensive Care Unit				75					
6.	Coronary Care Unit				30					
7.	Newborn ICU									
8.	Burn ICU				8					
9.	UH Surg 6IC				1					
10.	UH NS 3IC				15					
11.	RH Ped IC				90					
12.	Pediatric Cancer Center									
13.										
14.										
15.	Newborn Nursery									
16.	Total				1,079	0.32%				

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: 01/01/05 To: 12/31/05

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	0.435304	689,741			300,247		
2.	Recovery Room	0.461100	30,675			14,144		
3.	Delivery and Labor Room	0.506379	14,751			7,470		
4.	Anesthesiology	0.578396	34,358			19,873		
5.	Radiology - Diagnostic	0.227781	308,441			70,257		
6.	Radiology - Therapeutic	0.319021	11,738			3,745		
7.	Nuclear Medicine	0.384708	8,442			3,248		
8.	Laboratory	0.228204	586,611			133,867		
9.	Blood							
10.	Blood - Administration	0.593054	58,735			34,833		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.335204	746,392			250,194		
13.	Physical Therapy	0.607031	40,398			24,523		
14.	Occupational Therapy	0.713119	34,416			24,543		
15.	Speech Pathology	0.965042	24,220			23,373		
16.	EKG	0.169033	17,511			2,960		
17.	EEG	0.572903	12,993			7,444		
18.	Med. / Surg. Supplies	0.390745	49,478			19,333		
19.	Drugs Charged to Patients	0.387307	398,396			154,302		
20.	Renal Dialysis	0.456732	657			300		
21.	Ambulance	0.702389						
22.	Endoscopy Unit	0.298572	4,682			1,398		
23.	Pulmonary Function	0.521744	13,414			6,999		
23.01	Transplant Immunology	0.441220	303			134		
23.02	Bone Marrow Transplant Lab	0.514213	17,407			8,951		
23.03	RH NBN ECMO IC	0.737092						
23.04	Cardiology	0.204247	44,844			9,159		
23.05	Psych Other Ancillary	2.204754						
23.06	Cardiac Catheterization	0.247239						
23.07	Day Surgery	3.658464	713			2,608		
23.08	Oncology	0.541800						
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	2.748703						
<b>Outpatient Service Cost Centers</b>								
24.	"Clinics": Lines 60.01 through 60.25	1.219871	555			677		
25.	Emergency, ER Admitting	0.272559	74,147			20,209		
26.	Observ Beds:Non-distinct & Distinct	0.824649						
27.	<b>Total</b>		3,224,018			1,144,791		

\* 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: 01/01/05 To: 12/31/05

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)	\$ 854.43	\$ 1,049.62	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	860			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 734,810	\$	\$	\$
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)	\$ 734,810	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,846.20	75	\$ 138,465
9.	Coronary Care Unit	\$ 1,703.52	30	\$ 51,106
10.	Newborn ICU	\$ 963.33		\$
11.	Burn ICU	\$ 1,623.98	8	\$ 12,992
12.	UH Surg 6IC	\$ 1,666.62	1	\$ 1,667
13.	UH NS 3IC	\$ 1,634.84	15	\$ 24,523
14.	RH Ped IC	\$ 1,799.55	90	\$ 161,960
15.	Pediatric Cancer Center	\$ 1,445.15		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 3,962.10		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,144,791
18.	<b>Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)</b>			<b>\$ 2,270,314</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: 01/01/05 To: 12/31/05

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: 01/01/05 To: 12/31/05

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	363,781	344,326,090	0.001057	689,741			729		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	1,278,321	21,538,361	0.059351	34,358			2,039		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory	60,000	328,237,928	0.000183	586,611			107		
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy	119,755	18,325,428	0.006535	40,398			264		
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	964,343	35,599,478	0.027089	17,511			474		
17.	EEG	29,973	7,578,753	0.003955	12,993			51		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	221,250	34,851,673	0.006348	657			4		
21.	Ambulance	315,462	17,946,153	0.017578						
22.	Endoscopy Unit									
23.	Pulmonary Function	50,000	11,902,495	0.004201	13,414			56		
23.01	Transplant Immunology	143,000	9,067,920	0.015770	303			5		
23.02	Bone Marrow Transplant Lab									
23.03	RH NBN ECMO IC									
23.04	Cardiology									
23.05	Psych Other Ancillary									
23.06	Cardiac Catheterization	1,815,987	47,919,454	0.037897						
23.07	Day Surgery									
23.08	Oncology	275,000	4,114,082	0.066844						
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr									
<b>Outpatient Ancillary Cost Centers</b>										
24.	"Clinics": Lines 60.01 through 60.25	1,660,168	41,543,097	0.039963	555			22		
25.	Emergency, ER Admitting	5,845,860	115,669,272	0.050539	74,147			3,747		
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	1,149,370	284,313	4.04	860			3,474		
28.	Behavioral Care Center	289,250	8,242	35.09						
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Newborn ICU	350,804	9,053	38.75						
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>							10,972		

\* 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: 01/01/05 To: 12/31/05	
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)	2,270,314	
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)	10,972	
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>	2,281,286	
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)	3,224,018
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,148,235
	B. Behavioral Care Center	
	C.	
	D.	
	E. Intensive Care Unit	175,790
	F. Coronary Care Unit	66,582
	G. Newborn ICU	
	H. Burn ICU	20,642
	I. UH Surg 6IC	2,018
	J. UH NS 3IC	34,300
	K. RH Ped IC	221,391
	L. Pediatric Cancer Center	
	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>	4,892,976
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,611,690
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**

<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: 01/01/05 To: 12/31/05

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)	2,281,286		
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)	2,281,286		
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>	2,281,286		

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: 01/01/05 To: 12/31/05

**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)	2,611,690
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)
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**

Medicare Provider Number: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/05 To: 12/31/05

**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: 01/01/05 To: 12/31/05

**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	149,886,502	344,326,090	0.435304
2.	Recovery Room	18,498,863	40,119,013	0.461100
3.	Delivery and Labor Room	18,917,766	37,358,900	0.506379
4.	Anesthesiology	12,457,709	21,538,361	0.578396
5.	Radiology - Diagnostic	71,852,819	315,447,320	0.227781
6.	Radiology - Therapeutic	12,700,430	39,810,691	0.319021
7.	Nuclear Medicine	6,503,580	16,905,220	0.384708
8.	Laboratory	74,905,101	328,237,928	0.228204
9.	Blood			
10.	Blood - Administration	21,812,074	36,779,210	0.593054
11.	Intravenous Therapy			
12.	Respiratory Therapy	32,990,125	98,418,087	0.335204
13.	Physical Therapy	11,124,096	18,325,428	0.607031
14.	Occupational Therapy	4,199,585	5,889,039	0.713119
15.	Speech Pathology	6,248,658	6,475,012	0.965042
16.	EKG	6,017,476	35,599,478	0.169033
17.	EEG	4,341,894	7,578,753	0.572903
18.	Med. / Surg. Supplies	64,751,371	165,712,423	0.390745
19.	Drugs Charged to Patients	97,013,759	250,482,843	0.387307
20.	Renal Dialysis	15,917,878	34,851,673	0.456732
21.	Ambulance	12,605,175	17,946,153	0.702389
22.	Endoscopy Unit	3,040,863	10,184,690	0.298572
23.	Pulmonary Function	6,210,061	11,902,495	0.521744
23.01	Transplant Immunology	4,000,950	9,067,920	0.441220
23.02	Bone Marrow Transplant Lab	1,653,845	3,216,267	0.514213
23.03	RH NBN ECMO IC	1,067,954	1,448,874	0.737092
23.04	Cardiology	9,229,778	45,189,264	0.204247
23.05	Psych Other Ancillary	1,610,771	730,590	2.204754
23.06	Cardiac Catheterization	11,847,553	47,919,454	0.247239
23.07	Day Surgery	8,771,686	2,397,642	3.658464
23.08	Oncology	2,229,011	4,114,082	0.541800
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	25,909,358	9,426,031	2.748703
<b>Outpatient Ancillary Centers</b>				
24.	"Clinics": Lines 60.01 through 60.25	50,677,228	41,543,097	1.219871
25.	Emergency, ER Admitting	31,526,686	115,669,272	0.272559
26.	Observ Beds:Non-distinct & Distinct	12,154,159	14,738,584	0.824649
<b>Routine Service Cost Centers</b>			<b>Total Days</b>	<b>Per Diem</b>
27.	Adults and Pediatrics	242,925,299	284,313	854.43
28.	Behavioral Care Center	8,651,003	8,242	1,049.62
29.				
30.				
31.	Intensive Care Unit	31,090,049	16,840	1,846.20
32.	Coronary Care Unit	21,658,549	12,714	1,703.52
33.	Newborn ICU	8,721,070	9,053	963.33
34.	Burn ICU	2,627,594	1,618	1,623.98
35.	UH Surg 6IC	9,696,373	5,818	1,666.62
35.01	UH NS 3IC	4,417,345	2,702	1,634.84
35.02	RH Ped IC	16,021,395	8,903	1,799.55
35.03	Pediatric Cancer Center	2,523,224	1,746	1,445.15
35.04				
35.05				
36.	Nursery	5,309,210	1,340	3,962.10

**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: 01/01/05 To: 12/31/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,079		1,079
Newborn Days			
Total Inpatient Revenue	4,892,976		4,892,976
Ancillary Revenue	3,224,018		3,224,018
Routine Revenue	1,668,958		1,668,958
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:**

Hospital and Subprovider Discharges come from W/S S-3.

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.

Included \$20,016 in Nursery charges with Adults & Peds. This report has 0 Nursery Days.