

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: University of Iowa Hospital & Clinics		Medicare Provider Number: 16-0058
Street: 200 Hawkins Drive		Public Aid Provider Number: 9003
City: Iowa City	State: Iowa	Zip: 52242-1009
Period Covered by Statement:	From: 7-01-05	To: 6-30-06

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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)) University of Iowa Hospital & 9003 for the cost report beginning 7-01-05 and ending 6-30-06 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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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	497	173,225		112,254	64.80%		23,668	6.35	
2.	Psychiatric Hospital	73	26,645		22,204	83.33%		2,354	9.43	
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit	12	4,380		3,086	70.46%				
7.	Medical ICU	12	4,380		3,693	84.32%				
8.	Burn ICU	16	5,840		4,740	81.16%				
9.	ICU/ Surgical ICU	34	12,410		8,377	67.50%				
10.	Neonatal ICU	55	20,075		18,050	89.91%				
11.										
12.										
13.										
14.										
15.	Newborn Nursery	15	5,475		2,613	47.73%				
16.	Total	714	252,430		175,017	69.33%		26,022	6.63	
17.	Observation Bed Days				2,077					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				547			130	6.02	
2.	Psychiatric Hospital									
3.										
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit				7					
7.	Medical ICU				10					
8.	Burn ICU									
9.	ICU/ Surgical ICU				143					
10.	Neonatal ICU				75					
11.										
12.										
13.										
14.										
15.	Newborn Nursery				335					
16.	Total				1,117	0.64%		130	6.02	

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:	16-0058	Public Aid Provider Number:	9003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 7-01-05 To: 6-30-06

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	0.378442	470,730			178,144		
2.	Digestive Disease Center	0.273394	2,260			618		
3.	Delivery and Labor Room	0.667874	22,254			14,863		
4.	Anesthesiology	0.603629	56,722			34,239		
5.	Radiology - Diagnostic	0.266508	220,867			58,863		
6.	Radiology - Therapeutic	0.351523	8,074			2,838		
7.	Family Care Clinic- Line 60.15	1.103586	65,520			72,307		
8.	Laboratory	0.233100	505,123			117,744		
9.								
10.	Blood - Administration	0.478886	103,717			49,669		
11.								
12.	Respiratory Therapy	0.289976	241,383			69,995		
13.	Physical Therapy	0.482095	21,595			10,411		
14.	Occupational Therapy	0.494290	12,636			6,246		
15.								
16.	EKG	0.232388	38,399			8,923		
17.	EEG	0.308992	3,092			955		
18.	Med. / Surg. Supplies	0.445759	259,371			115,617		
19.	Drugs Charged to Patients	0.576210	422,405			243,394		
20.	Renal Dialysis	0.410803	10,848			4,456		
21.	Ambulance/ Emer Mobile Crit Care	0.396000	63,785			25,259		
22.	Ultrasound	0.400900						
23.	Radiology- PET Scan	0.448697						
23.01	Anatomical Laboratory	0.575472						
23.02	Cardiology	0.200079	23,208			4,643		
23.03	Orthotic Services	0.650836						
23.04								
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.269300	35,660			9,603		
26.	Observation Beds (Non-distinct Par	0.425525	994			423		
27.	Total		2,588,643			1,029,210		

* 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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Hospital	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 866.94	\$ 693.99	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	547			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 474,216	\$	\$	\$
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)	\$ 474,216	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$		\$
9.	Coronary Care Unit	\$ 1,614.52	7	\$ 11,302
10.	Medical ICU	\$ 1,636.81	10	\$ 16,368
11.	Burn ICU	\$ 1,279.07		\$
12.	ICU/ Surgical ICU	\$ 1,644.93	143	\$ 235,225
13.	Neonatal ICU	\$ 974.87	75	\$ 73,115
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 525.46	335	\$ 176,029
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,029,210
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,015,465

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

Medicare Provider Number: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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.	Psychiatric Hospital						
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Medical ICU						
9.	Burn ICU						
10.	ICU/ Surgical ICU						
10.01	Neonatal ICU						
10.02							
10.03							
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.	Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct F										
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:	16-0058	Public Aid Provider Number:	9003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 7-01-05 To: 6-30-06

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.	Digestive Disease Center									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Family Care Clinic- Line 60.15									
8.	Laboratory									
9.										
10.	Blood - Administration									
11.										
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.										
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance/ Emer Mobile Crit Care									
22.	Ultrasound									
23.	Radiology- PET Scan									
23.01	Anatomical Laboratory									
23.02	Cardiology									
23.03	Orthotic Services									
23.04										
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Hospital									
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Medical ICU									
34.	Burn ICU									
35.	ICU/ Surgical ICU									
35.01	Neonatal ICU									
35.02										
35.03										
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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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)	2,015,465		
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)	2,015,465		
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)	2,588,643
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	2,133,330
	B. Psychiatric Hospital	
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Medical ICU	
	H. Burn ICU	
	I. ICU/ Surgical ICU	
	J. Neonatal ICU	
	K.	
	L.	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	4,721,973
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,706,508
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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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)	2,015,465		
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)	2,015,465		
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)	2,015,465		

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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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)	2,706,508
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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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 Psychiatric Hosp	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 Psychiatric Hosp	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 Psychiatric Hosp	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: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

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	68,701,337	181,537,093	0.378442
2.	Digestive Disease Center	4,632,173	16,943,233	0.273394
3.	Delivery and Labor Room	5,341,573	7,997,870	0.667874
4.	Anesthesiology	12,694,786	21,030,772	0.603629
5.	Radiology - Diagnostic	41,026,142	153,939,560	0.266508
6.	Radiology - Therapeutic	9,749,586	27,735,279	0.351523
7.	Family Care Clinic- Line 60.15	10,875,245	9,854,457	1.103586
8.	Laboratory	32,049,885	137,494,342	0.233100
9.				
10.	Blood - Administration	7,023,736	14,666,818	0.478886
11.				
12.	Respiratory Therapy	10,418,417	35,928,500	0.289976
13.	Physical Therapy	3,965,885	8,226,348	0.482095
14.	Occupational Therapy	1,470,187	2,974,342	0.494290
15.				
16.	EKG	858,364	3,693,663	0.232388
17.	EEG	2,227,814	7,209,936	0.308992
18.	Med. / Surg. Supplies	33,083,134	74,217,528	0.445759
19.	Drugs Charged to Patients	66,371,024	115,185,389	0.576210
20.	Renal Dialysis	5,758,101	14,016,693	0.410803
21.	Ambulance/ Emer Mobile Crit Care	4,301,348	10,861,999	0.396000
22.	Ultrasound	2,452,690	6,117,959	0.400900
23.	Radiology- PET Scan	3,038,576	6,771,995	0.448697
23.01	Anatomical Laboratory	8,342,482	14,496,765	0.575472
23.02	Cardiology	9,578,189	47,872,027	0.200079
23.03	Orthotic Services	1,750,414	2,689,487	0.650836
23.04				
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	9,184,635	34,105,628	0.269300
26.	Observation Beds (Non-distinct Part)	1,658,443	3,897,406	0.425525
Routine Service Cost Centers				
27.	Adults and Pediatrics	99,117,812	114,331	866.94
28.	Psychiatric Hospital	15,409,309	22,204	693.99
29.				
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit	4,982,397	3,086	1,614.52
33.	Medical ICU	6,044,721	3,693	1,636.81
34.	Burn ICU	6,062,795	4,740	1,279.07
35.	ICU/ Surgical ICU	13,779,577	8,377	1,644.93
35.01	Neonatal ICU	17,596,356	18,050	974.87
35.02				
35.03				
35.04				
35.05				
36.	Nursery	1,373,036	2,613	525.46

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

PRELIMINARY

Medicare Provider Number: 16-0058	Public Aid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 7-01-05 To: 6-30-06

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	782		782
Newborn Days	335		335
Total Inpatient Revenue	4,721,972	1	4,721,973
Ancillary Revenue	2,588,642	1	2,588,643
Routine Revenue	2,133,330		2,133,330
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:

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

Included the \$16,723 in Recovery Room charges with Operating Room.

Included the \$3,950 in IV Therapy charges with Drugs (which has a cost:charge ratio).

Included the \$6,696 in Speech Path. Charges with Occupational Therapy (which has a cost: charge ratio).

Included the \$9,555 in Nuclear Medicine Charges with Radiology-Diagnostic.

Included the \$65,520 in Other Charges with Family Care Clinic.

All these charges were reclassified per the prior year cost report adjustments.