

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: 01/01/06	To: 12/31/06	

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 01/01/06 and ending 12/31/06 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: 15-0056	Public Aid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/06 To: 12/31/06

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	1,055	385,075		260,645	67.69%		53,591	5.97	
2.	Behavioral Care Center	47	17,155		7,445	43.40%		935	7.96	
3.										
4.										
5.	Intensive Care Unit	68	24,820		17,062	68.74%				
6.	Coronary Care Unit	84	30,660		12,564	40.98%				
7.	Newborn ICU	35	12,775		7,886	61.73%				
8.	Burn ICU	7	2,555		1,603	62.74%				
9.	UH Surg 6IC	18	6,570		5,836	88.83%				
10.	UH NS 3IC	9	3,285		2,616	79.63%				
11.	RH Ped IC	36	13,140		9,861	75.05%				
12.	Pediatric Cancer Center	6	2,190		1,880	85.84%				
13.										
14.										
15.	Newborn Nursery	45	16,470		7,653	46.47%				
16.	Total	1,410	514,695		335,051	65.10%		54,526	6.00	
17.	Observation Bed Days				16,144					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				644					
2.	Behavioral Care Center									
3.										
4.										
5.	Intensive Care Unit				7					
6.	Coronary Care Unit									
7.	Newborn ICU				10					
8.	Burn ICU				31					
9.	UH Surg 6IC				67					
10.	UH NS 3IC				54					
11.	RH Ped IC				5					
12.	Pediatric Cancer Center									
13.										
14.										
15.	Newborn Nursery									
16.	Total				818	0.24%				

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: 01/01/06 To: 12/31/06

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	0.347597	968,106			336,511		
2.	Recovery Room	0.395908	44,346			17,557		
3.	Delivery and Labor Room	0.429224	44,337			19,031		
4.	Anesthesiology	0.733658	45,758			33,571		
5.	Radiology - Diagnostic	0.208440	453,652			94,559		
6.	Radiology - Therapeutic	0.277972	8,951			2,488		
7.	Nuclear Medicine	0.335908	5,543			1,862		
8.	Laboratory	0.223463	477,567			106,719		
9.	Blood							
10.	Blood - Administration	0.454447	74,321			33,775		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.261026	404,731			105,645		
13.	Physical Therapy	0.516976	16,536			8,549		
14.	Occupational Therapy	0.563068	11,779			6,632		
15.	Speech Pathology	0.685761	9,261			6,351		
16.	EKG	0.143661	18,888			2,713		
17.	EEG	0.516595	25,020			12,925		
18.	Med. / Surg. Supplies	0.083776	45,010			3,771		
19.	Drugs Charged to Patients	0.289403	612,478			177,253		
20.	Renal Dialysis	0.563239	10,909			6,144		
21.	Ambulance	0.727676						
22.	Endoscopy Unit	0.303724	3,869			1,175		
23.	Pulmonary Function	0.472607	11,696			5,528		
23.01	Transplant Immunology	0.399990	313			125		
23.02	Bone Marrow Transplant Lab	0.397815	1,166			464		
23.03	Cardiology	0.307349	35,373			10,872		
23.04	Day Surgery	3.121456	361			1,127		
23.05	RH NBN ECMO IC	0.704352						
23.06	Psych Other Ancillary	1.684412						
23.07	Cardiac Catheterization	0.312588						
23.08	Oncology	0.768725						
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	1.034464						
Outpatient Service Cost Centers								
24.	"Clinics": Lines 60.01 through 60.25	1.313657	3,031			3,982		
25.	Emergency	0.285372	35,329			10,082		
26.	Observation Beds	0.730364						
27.	Total		3,368,331			1,009,411		

* 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: 01/01/06 To: 12/31/06

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)	\$ 826.14	\$ 1,036.97	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	644			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 532,034	\$	\$	\$
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)	\$ 532,034	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,657.35	7	\$ 11,601
9.	Coronary Care Unit	\$ 1,610.74		\$
10.	Newborn ICU	\$ 960.84	10	\$ 9,608
11.	Burn ICU	\$ 1,660.62	31	\$ 51,479
12.	UH Surg 6IC	\$ 1,652.25	67	\$ 110,701
13.	UH NS 3IC	\$ 1,549.54	54	\$ 83,675
14.	RH Ped IC	\$ 1,623.49	5	\$ 8,117
15.	Pediatric Cancer Center	\$ 1,261.31		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$ 623.90		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,009,411
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,816,626

**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: 01/01/06 To: 12/31/06

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.	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.	Observation Beds										
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: 01/01/06 To: 12/31/06

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	877,804	463,451,178	0.001894	968,106			1,834		
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology	1,808,396	25,120,216	0.071990	45,758			3,294		
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG	922,056	42,097,273	0.021903	18,888			414		
17.	EEG	31,661	8,467,031	0.003739	25,020			94		
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis	189,583	39,090,179	0.004850	10,909			53		
21.	Ambulance	272,071	21,352,374	0.012742						
22.	Endoscopy Unit									
23.	Pulmonary Function									
23.01	Transplant Immunology	51,500	10,467,100	0.004920	313			2		
23.02	Bone Marrow Transplant Lab									
23.03	Cardiology									
23.04	Day Surgery									
23.05	RH NBN ECMO IC									
23.06	Psych Other Ancillary									
23.07	Cardiac Catheterization	1,941,697	64,300,153	0.030197						
23.08	Oncology									
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr									
Outpatient Ancillary Cost Centers										
24.	"Clinics": Lines 60.01 through 60.25	1,461,405	45,679,960	0.031992	3,031			97		
25.	Emergency	5,671,293	126,534,533	0.044820	35,329			1,583		
26.	Observation Beds									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics	1,992,636	276,789	7.20	644			4,637		
28.	Behavioral Care Center	425,750	7,445	57.19						
29.										
30.										
31.	Intensive Care Unit	562,800	17,062	32.99	7			231		
32.	Coronary Care Unit	351,728	12,564	27.99						
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							12,239		

* 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: 01/01/06 To: 12/31/06		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	1,816,626		
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)	12,239		
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)	1,828,865		
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)	3,368,331
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	654,494
	B. Behavioral Care Center	
	C.	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	15,051
	G. Newborn ICU	
	H. Burn ICU	25,664
	I. UH Surg 6IC	71,492
	J. UH NS 3IC	152,390
	K. RH Ped IC	141,153
	L. Pediatric Cancer Center	7,809
	M.	
	N.	
	O. Nursery	82,549
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	4,518,933
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	2,690,068
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: 01/01/06 To: 12/31/06

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)	1,828,865		
2.	Excess Reasonable Cost (OHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,828,865		
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)	1,828,865		

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: 01/01/06 To: 12/31/06

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)	2,690,068
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.	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: 01/01/06 To: 12/31/06

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 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: 01/01/06 To: 12/31/06

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	161,094,304	463,451,178	0.347597
2.	Recovery Room	15,722,611	39,712,838	0.395908
3.	Delivery and Labor Room	16,437,575	38,296,037	0.429224
4.	Anesthesiology	18,429,639	25,120,216	0.733658
5.	Radiology - Diagnostic	77,370,604	371,189,208	0.208440
6.	Radiology - Therapeutic	12,268,926	44,137,311	0.277972
7.	Nuclear Medicine	5,784,758	17,221,272	0.335908
8.	Laboratory	77,264,811	345,761,264	0.223463
9.	Blood			
10.	Blood - Administration	19,704,284	43,358,851	0.454447
11.	Intravenous Therapy			
12.	Respiratory Therapy	32,543,151	124,674,090	0.261026
13.	Physical Therapy	10,486,657	20,284,604	0.516976
14.	Occupational Therapy	4,168,804	7,403,728	0.563068
15.	Speech Pathology	8,087,634	11,793,671	0.685761
16.	EKG	6,047,751	42,097,273	0.143661
17.	EEG	4,374,026	8,467,031	0.516595
18.	Med. / Surg. Supplies	1,033,236	12,333,380	0.083776
19.	Drugs Charged to Patients	80,406,925	277,837,581	0.289403
20.	Renal Dialysis	22,017,129	39,090,179	0.563239
21.	Ambulance	15,537,609	21,352,374	0.727676
22.	Endoscopy Unit	3,345,139	11,013,762	0.303724
23.	Pulmonary Function	6,381,349	13,502,430	0.472607
23.01	Transplant Immunology	4,186,731	10,467,100	0.399990
23.02	Bone Marrow Transplant Lab	1,876,818	4,717,816	0.397815
23.03	Cardiology	22,877,316	74,434,319	0.307349
23.04	Day Surgery	8,626,020	2,763,460	3.121456
23.05	RH NBN ECMO IC	836,987	1,188,307	0.704352
23.06	Psych Other Ancillary	1,522,444	903,843	1.684412
23.07	Cardiac Catheterization	20,099,467	64,300,153	0.312588
23.08	Oncology	2,246,136	2,921,898	0.768725
23.09	Acquis-Kid,Heart,Liver,Lung,Pancr	20,338,136	19,660,547	1.034464
Outpatient Ancillary Centers				
24.	"Clinics": Lines 60.01 through 60.25	60,007,791	45,679,960	1.313657
25.	Emergency	36,109,381	126,534,533	0.285372
26.	Observation Beds	12,862,893	17,611,624	0.730364
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	228,666,221	276,789	826.14
28.	Behavioral Care Center	7,720,247	7,445	1,036.97
29.				
30.				
31.	Intensive Care Unit	28,277,754	17,062	1,657.35
32.	Coronary Care Unit	20,237,321	12,564	1,610.74
33.	Newborn ICU	7,577,171	7,886	960.84
34.	Burn ICU	2,661,975	1,603	1,660.62
35.	UH Surg 6IC	9,642,530	5,836	1,652.25
35.01	UH NS 3IC	4,053,598	2,616	1,549.54
35.02	RH Ped IC	16,009,207	9,861	1,623.49
35.03	Pediatric Cancer Center	2,371,261	1,880	1,261.31
35.04				
35.05				
36.	Nursery	4,774,721	7,653	623.90

