

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: Children's Hospital of Wisconsin		Medicare Provider Number: 52-3300
Street: 9000 W. Wisconsin Avenue, P.O. Box 1997		Public Aid Provider Number: 13029
City: Milwaukee	State: Wisconsin	Zip: 53201-1997
Period Covered by Statement:	From: 01-01-03	To: 12-31-03

Type of Control

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

Type of Hospital

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

Health Care Program

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

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

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Children's Hospital of Wisconsin: 13029 for the cost report beginning 01-01-03 and ending 12-31-03 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)

 Title

 Date

 Firm

 Telephone Number

 Name (Typewritten)

 Title

 Date

 Telephone Number

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Public Aid Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	125	45,625		37,186	81.50%		12,571	4.78	
2.										
3.										
4.										
5.	Intensive Care Unit	65	23,725		15,519	65.41%				
6.	Coronary Care Unit									
7.	Other Special Care/ HOT Unit	24	8,760		7,393	84.39%				
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total	214	78,110		60,098	76.94%		12,571	4.78	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				675			204	7.95	
2.										
3.										
4.										
5.	Intensive Care Unit				626					
6.	Coronary Care Unit									
7.	Other Special Care/ HOT Unit				321					
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.	Newborn Nursery									
16.	Total				1,622	2.70%		204	7.95	

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:	52-3300	Public Aid Provider Number:	13029
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-03 To: 12-31-03

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	1.012638	533,488			540,230		
2.	Recovery Room	0.586524	22,549			13,226		
3.	Delivery and Labor Room							
4.	Anesthesiology	0.633715	80,582			51,066		
5.	Radiology - Diagnostic	0.373284	266,731			99,566		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine- Therapeutic	0.607187	7,006			4,254		
8.	Laboratory	0.285496	1,194,454			341,012		
9.	Blood							
10.	Blood - Administration	0.819113	198,095			162,262		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.498685	457,276			228,037		
13.	Physical Therapy	0.540599	62,129			33,587		
14.	Occupational Therapy							
15.	Speech Pathology	0.710374	25,266			17,948		
16.	EKG	0.572298	88,041			50,386		
17.	EEG	0.482631	8,002			3,862		
18.	Med. / Surg. Supplies	0.422042	615,099			259,598		
19.	Drugs Charged to Patients	0.455982	908,632			414,320		
20.	Renal Dialysis	0.369412						
21.	Ambulance/ Transport	1.131616	286,113			323,770		
22.	Psychiatry Center	1.258106						
23.	Genetics Center	4.157068	1,477			6,140		
23.01	Child Development Center	2.301417						
23.02	Child Protection Center	2.603946						
23.03	Dental Services	0.956947						
23.04	Cross Continuum Case Management	8.424254						
23.05								
23.06								
23.07								
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Lines 60-02 through 60-37/ Clinics	1.384819	3,439			4,762		
25.	Emergency	1.181397	19,556			23,103		
26.	Observation Beds (Non-distinct Par							
27.	Total		4,777,935			2,577,129		

* 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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

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

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 888.27	\$	\$	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	675			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 599,582	\$	\$	\$
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)	\$ 599,582	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,454.01	626	\$ 910,210
9.	Coronary Care Unit	\$		\$
10.	Other Special Care/ HOT Unit	\$ 1,217.85	321	\$ 390,930
11.		\$		\$
12.		\$		\$
13.		\$		\$
14.		\$		\$
15.		\$		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 2,577,129
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 4,477,851

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

Medicare Provider Number: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (OHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (OHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.							
4.							
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other Special Care/ HOT Unit						
9.							
10.							
10.01							
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.	Lines 60-02 through 60-37/ Clinic										
14.	Emergency										
15.	Observation Beds (Non-distinct P										
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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (OHF Page 3, Col. 2)	Outpatient Program Charges (OHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology - Diagnostic									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine- Therapeutic									
8.	Laboratory									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance/ Transport									
22.	Psychiatry Center									
23.	Genetics Center									
23.01	Child Development Center									
23.02	Child Protection Center									
23.03	Dental Services									
23.04	Cross Continuum Case Management									
23.05										
23.06										
23.07										
23.08										
23.09										
Outpatient Ancillary Cost Centers										
24.	Lines 60-02 through 60-37/ Clinics									
25.	Emergency									
26.	Observation Beds (Non-distinct Part)									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.										
29.										
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Other Special Care/ HOT Unit									
34.										
35.										
35.01										
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: 52-3300		Public Aid Provider Number: 13029		
Program: Medicaid-Hospital		Period Covered by Statement: From: 01-01-03 To: 12-31-03		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (OHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (OHF Page 4, Line 18)	4,477,851		
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)	4,477,851		
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)	4,777,935
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	1,237,839
	B.	
	C.	
	D.	
	E. Intensive Care Unit	2,291,087
	F. Coronary Care Unit	
	G. Other Special Care/ HOT Unit	416,821
	H.	
	I.	
	J.	
	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)	8,723,682
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	4,245,831
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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (OHF Page 7, Line 6, Cols. 1, 2, & 3)	4,477,851		
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)	4,477,851		
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)	4,477,851		

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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (OHF Page 7, Line 12)	4,245,831
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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I	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	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	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: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to OHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	20,744,450	20,485,554	1.012638
2.	Recovery Room	2,242,608	3,823,554	0.586524
3.	Delivery and Labor Room			
4.	Anesthesiology	2,812,737	4,438,489	0.633715
5.	Radiology - Diagnostic	13,092,810	35,074,637	0.373284
6.	Radiology - Therapeutic			
7.	Nuclear Medicine- Therapeutic	985,891	1,623,703	0.607187
8.	Laboratory	15,066,985	52,774,799	0.285496
9.	Blood			
10.	Blood - Administration	10,044,406	12,262,533	0.819113
11.	Intravenous Therapy			
12.	Respiratory Therapy	7,242,754	14,523,696	0.498685
13.	Physical Therapy	2,829,901	5,234,754	0.540599
14.	Occupational Therapy			
15.	Speech Pathology	3,127,686	4,402,873	0.710374
16.	EKG	4,069,024	7,109,978	0.572298
17.	EEG	1,235,565	2,560,060	0.482631
18.	Med. / Surg. Supplies	21,527,838	51,008,804	0.422042
19.	Drugs Charged to Patients	19,229,957	42,172,585	0.455982
20.	Renal Dialysis	949,967	2,571,564	0.369412
21.	Ambulance/ Transport	3,533,316	3,122,363	1.131616
22.	Psychiatry Center	1,786,697	1,420,148	1.258106
23.	Genetics Center	881,951	212,157	4.157068
23.01	Child Development Center	803,634	349,191	2.301417
23.02	Child Protection Center	1,858,835	713,853	2.603946
23.03	Dental Services	3,731,380	3,899,256	0.956947
23.04	Cross Continuum Case Management	550,466	65,343	8.424254
23.05				
23.06				
23.07				
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Lines 60-02 through 60-37/ Clinics	21,416,755	15,465,378	1.384819
25.	Emergency	9,761,771	8,262,902	1.181397
26.	Observation Beds (Non-distinct Part)			
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	33,031,092	37,186	888.27
28.				
29.				
30.				
31.	Intensive Care Unit	22,564,734	15,519	1,454.01
32.	Coronary Care Unit			
33.	Other Special Care/ HOT Unit	9,003,557	7,393	1,217.85
34.				
35.				
35.01				
35.02				
35.03				
35.04				
35.05				
36.	Nursery			

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

PRELIMINARY

Medicare Provider Number: 52-3300	Public Aid Provider Number: 13029
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-03 To: 12-31-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,622		1,622
Newborn Days			
Total Inpatient Revenue	8,723,682		8,723,682
Ancillary Revenue	4,777,935		4,777,935
Routine Revenue	3,945,747		3,945,747
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:

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

Classified \$6,456 Dietetics charges with Adults and Pediatrics.