

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 Wisconsin Hospital and Clinics		Medicare Provider Number: 52-0098	
Street: 600 Highland Avenue		Public Aid Provider Number: 13031	
City: Madison	State: Wisconsin	Zip: 53792	
Period Covered by Statement:	From: 07-01-02	To: 06-30-03	

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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) XXXX XXXX	<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)) University of Wisconsin Hospi 13031 for the cost report beginning 07-01-02 and ending 06-30-03 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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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	346	126,290		95,104	75.31%		19,131	5.99	
2.	Psychiatric Unit- B6/5	20	7,300		4,977	68.18%		760	6.55	
3.	Rehabilitation Unit- B4/4	22	8,030		5,254	65.43%		308	17.06	
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU	24	8,760		8,094	92.40%				
8.	Burn ICU	7	2,555		2,301	90.06%				
9.	Surgical ICU	8	2,920		2,187	74.90%				
10.	Medical ICU	8	2,920		1,767	60.51%				
11.	Pediatric ICU	18	6,570		3,067	46.68%				
12.	Neuro ICU	8	2,920		2,061	70.58%				
13.										
14.										
15.	Newborn Nursery									
16.	Total	461	168,265		124,812	74.18%		20,199	6.18	
17.	Observation Bed Days									

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				719			119	6.47	
2.	Psychiatric Unit- B6/5									
3.	Rehabilitation Unit- B4/4									
4.										
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU									
8.	Burn ICU									
9.	Surgical ICU				7					
10.	Medical ICU									
11.	Pediatric ICU				44					
12.	Neuro ICU									
13.										
14.										
15.	Newborn Nursery									
16.	Total				770	0.62%		119	6.47	

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:	52-0098	Public Aid Provider Number:	13031
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07-01-02 To: 06-30-03

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	0.498753	436,996			217,953		
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	0.215070	77,988			16,773		
5.	Radiology - Diagnostic	0.301201	231,256			69,655		
6.	Radiology - Therapeutic	0.261860	16,286			4,265		
7.	Nuclear Medicine	0.440890	3,348			1,476		
8.	Laboratory	0.389025	397,238			154,536		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.492084	134,092			65,985		
13.	Physical Therapy	0.696372	71,234			49,605		
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.448443	138,648			62,176		
17.	EEG	0.319952	16,170			5,174		
18.	Med. / Surg. Supplies	0.777729	4,815			3,745		
19.	Drugs Charged to Patients	0.577582	551,550			318,565		
20.	Renal Dialysis	0.556039	23,441			13,034		
21.	Ambulance	0.804042						
22.	Neuropsych Testing	0.438332	407			178		
23.	Pulmonary Function	0.353145	3,417			1,207		
23.01	Orthotics Laboratory	0.600030	2,851			1,711		
23.02	CSC Clinics	0.939750	19,928			18,727		
23.03	Clinic University Station	0.973475	1,034			1,007		
23.04	Clinic Waisman	1.794977						
23.05	Clinic West	1.377047	1,086			1,495		
23.06	Clinic East	1.627309	303			493		
23.07	Clinic Research Park	0.716181	119			85		
23.08								
23.09								
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.566781	35,732			20,252		
26.	Observation Beds (Non-distinct Par							
27.	Total		2,167,939			1,028,097		

* 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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit- B6/5	Sub II Rehabilitation Unit- B4	Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,002.67	\$ 940.22	\$ 682.12	\$
2.	Program general inpatient routine days (OHF Page 2, Part II, Col. 4)	719			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 720,920	\$	\$	\$
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)	\$ 720,920	\$	\$	\$

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	\$		\$
10.	Trauma ICU	\$ 1,324.82		\$
11.	Burn ICU	\$ 1,614.30		\$
12.	Surgical ICU	\$ 1,559.87	7	\$ 10,919
13.	Medical ICU	\$ 1,525.41		\$
14.	Pediatric ICU	\$ 1,834.95	44	\$ 80,738
15.	Neuro ICU	\$ 1,312.50		\$
15.01		\$		\$
15.02		\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (OHF Page 3, Col. 5, Line 27)			\$ 1,028,097
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,840,674

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

Medicare Provider Number: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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.	Psychiatric Unit- B6/5						
4.	Rehabilitation Unit- B4/4						
5.							
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Trauma ICU						
9.	Burn ICU						
10.	Surgical ICU						
10.01	Medical ICU						
10.02	Pediatric ICU						
10.03	Neuro ICU						
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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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									
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									
22.	Neuropsych Testing									
23.	Pulmonary Function									
23.01	Orthotics Laboratory									
23.02	CSC Clinics									
23.03	Clinic University Station									
23.04	Clinic Waisman									
23.05	Clinic West									
23.06	Clinic East									
23.07	Clinic Research Park									
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 Unit- B6/5									
29.	Rehabilitation Unit- B4/4									
30.										
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Trauma ICU									
34.	Burn ICU									
35.	Surgical ICU									
35.01	Medical ICU									
35.02	Pediatric ICU									
35.03	Neuro ICU									
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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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)	1,840,674		
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)	1,840,674		
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)	2,167,939
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	998,536
	B. Psychiatric Unit- B6/5	
	C. Rehabilitation Unit- B4/4	
	D.	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Trauma ICU	
	H. Burn ICU	
	I. Surgical ICU	
	J. Medical ICU	
	K. Pediatric ICU	71,764
	L. Neuro ICU	
	M.	
	N.	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	3,238,239
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,397,565
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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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)	1,840,674		
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)	1,840,674		
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)	1,840,674		

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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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)	1,397,565
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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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 Psychiatric Unit	Sub II Rehabilitation Ur	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 Unit	Sub II Rehabilitation Ur	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 Unit	Sub II Rehabilitation Ur	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: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

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	56,654,648	113,592,644	0.498753
2.	Recovery Room			
3.	Delivery and Labor Room			
4.	Anesthesiology	5,747,346	26,723,124	0.215070
5.	Radiology - Diagnostic	36,770,277	122,078,868	0.301201
6.	Radiology - Therapeutic	6,864,221	26,213,329	0.261860
7.	Nuclear Medicine	2,797,724	6,345,622	0.440890
8.	Laboratory	36,542,073	93,932,353	0.389025
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	11,383,324	23,132,865	0.492084
13.	Physical Therapy	13,417,808	19,268,153	0.696372
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	20,442,961	45,586,483	0.448443
17.	EEG	1,265,473	3,955,194	0.319952
18.	Med. / Surg. Supplies	986,926	1,268,985	0.777729
19.	Drugs Charged to Patients	81,019,864	140,274,265	0.577582
20.	Renal Dialysis	4,649,253	8,361,385	0.556039
21.	Ambulance	3,453,066	4,294,636	0.804042
22.	Neuropsych Testing	296,842	677,208	0.438332
23.	Pulmonary Function	1,090,604	3,088,265	0.353145
23.01	Orthotics Laboratory	1,561,225	2,601,913	0.600030
23.02	CSC Clinics	35,417,593	37,688,300	0.939750
23.03	Clinic University Station	8,137,606	8,359,334	0.973475
23.04	Clinic Waisman	585,132	325,983	1.794977
23.05	Clinic West	15,270,893	11,089,596	1.377047
23.06	Clinic East	7,336,009	4,508,062	1.627309
23.07	Clinic Research Park	3,165,001	4,419,278	0.716181
23.08				
23.09				
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	7,933,130	13,996,816	0.566781
26.	Observation Beds (Non-distinct Part)			
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	95,358,081	95,104	1,002.67
28.	Psychiatric Unit- B6/5	4,679,497	4,977	940.22
29.	Rehabilitation Unit- B4/4	3,583,863	5,254	682.12
30.				
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Trauma ICU	10,723,120	8,094	1,324.82
34.	Burn ICU	3,714,500	2,301	1,614.30
35.	Surgical ICU	3,411,441	2,187	1,559.87
35.01	Medical ICU	2,695,401	1,767	1,525.41
35.02	Pediatric ICU	5,627,795	3,067	1,834.95
35.03	Neuro ICU	2,705,069	2,061	1,312.50
35.04				
35.05				
36.	Nursery			

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

PRELIMINARY

Medicare Provider Number: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07-01-02 To: 06-30-03

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	770		770
Newborn Days			
Total Inpatient Revenue	3,245,358	(7,119)	3,238,239
Ancillary Revenue	2,175,058	(7,119)	2,167,939
Routine Revenue	1,070,300		1,070,300
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:

There was no adjustment to the filed W/S C charges to prepare the filed OHF report.

Removed \$7,119 Home Program Dialysis charges as non-covered.

Per David Pezewski 12-01-03, all clinics are hospital-based. None are free-standing.

As "Clinics" costs = \$2,173,529 were allocated to W/S B, Part I, Lines 60.01 through 60.06, those adjustments are included with the column 25 costs.

Per David Pezewski 12-01-03, there are no Illinois Medicaid organ acquisitions.