

Hospital Statement of Cost

Illinois Department of Public Aid, Bureau 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: 07/01/04	To: 06/30/05

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input 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 XXXX XXXX	<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 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)) University of Wisconsin Hospi 13031 for the cost report beginning 07/01/04 and ending 06/30/05 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

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

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	355	129,575		94,193	72.69%		22,428	5.05	
2.	Psychiatric Unit	20	7,300		5,207	71.33%		879	5.92	
3.	Rehabilitation Unit	21	7,665		6,076	79.27%		406	14.97	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU	24	8,760		7,329	83.66%				
8.	Burn ICU	7	2,555		1,858	72.72%				
9.	Surgical ICU	8	2,920		2,127	72.84%				
10.	Medical ICU	8	2,920		1,589	54.42%				
11.	Pediatric ICU	18	6,570		3,074	46.79%				
12.	Neuro ICU	10	3,650		3,112	85.26%				
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total	471	171,915		124,565	72.46%		23,713	5.25	
17.	Observation Bed Days				1,400					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				338			60	6.52	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU				25					
8.	Burn ICU				13					
9.	Surgical ICU									
10.	Medical ICU				15					
11.	Pediatric ICU									
12.	Neuro ICU									
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				391	0.31%		60	6.52	

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: 07/01/04 To: 06/30/05

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement) (1)	Total Billed I/P Charges (Gross) for Health Care Program Patients (2)	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2) (5)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients (3)	Total Billed O/P Charges (Gross) for Health Care Program Patients (4)		O/P Expenses Applicable to Health Care Program (Col. 1 X 3) (6)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4) (7)
1.	Operating Room	0.416580	372,724			155,269		
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	0.335285	80,753			27,075		
5.	Radiology - Diagnostic	0.276965	177,217			49,083		
6.	Radiology - Therapeutic	0.252207	4,278			1,079		
7.	Nuclear Medicine	0.482956	3,134			1,514		
8.	Laboratory	0.360270	177,714			64,025		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.617716	45,535			28,128		
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.407265	122,025			49,697		
17.	EEG	0.286814	5,738			1,646		
18.	Med. / Surg. Supplies	0.326423	4,393			1,434		
19.	Drugs Charged to Patients	0.443238	250,563			111,059		
20.	Renal Dialysis	0.442975	13,255			5,872		
21.	Ambulance	0.459811	44			20		
22.	Neuro Psych Testing	0.369344	163			60		
23.	Rehab Services	0.677068	32,782			22,196		
23.01	Pulmonary Function	0.347886	784			273		
23.02	Orthotics Lab	0.583590	2,446			1,427		
23.03	CSC Clinics	0.747317	13,554			10,129		
23.04	Clinic U Station	1.013826	192			195		
23.05	Clinic Waisman	1.107052	1			1		
23.06	Clinic West	1.365640	588			803		
23.07	Clinic East	1.242100	62			77		
23.08	Clinic Research Park	0.659449	30			20		
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.469833	28,792			13,527		
26.	Observation							
27.	Total		1,336,767			544,609		

* 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: 07/01/04 To: 06/30/05

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

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,147.91	\$ 1,047.35	\$ 842.48	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	338			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 387,994	\$	\$	\$
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 (BHF 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)	\$ 387,994	\$	\$	\$

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	\$ 1,936.86	25	\$ 48,422
11.	Burn ICU	\$ 2,085.74	13	\$ 27,115
12.	Surgical ICU	\$ 2,111.55		\$
13.	Medical ICU	\$ 2,196.46	15	\$ 32,947
14.	Pediatric ICU	\$ 2,194.34		\$
15.	Neuro ICU	\$ 1,347.04		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 544,609
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 1,041,087

**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: 07/01/04 To: 06/30/05

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (BHF Page 2, Part I, Col. 4)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF 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						
4.	Rehabilitation Unit						
5.	Sub III						
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	Other						
10.05	Other						
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										
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: 07/01/04 To: 06/30/05

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF 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.	Neuro Psych Testing									
23.	Rehab Services									
23.01	Pulmonary Function									
23.02	Orthotics Lab									
23.03	CSC Clinics									
23.04	Clinic U Station									
23.05	Clinic Waisman									
23.06	Clinic West									
23.07	Clinic East									
23.08	Clinic Research Park									
23.09	Other									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Psychiatric Unit									
29.	Rehabilitation Unit									
30.	Sub III									
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	Other									
35.05	Other									
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: 07/01/04 To: 06/30/05		
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient	
		(1)	Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	1,041,087		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	1,041,087		
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)	1,336,767
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	362,196
	B. Psychiatric Unit	
	C. Rehabilitation Unit	15,581
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Trauma ICU	70,592
	H. Burn ICU	14,878
	I. Surgical ICU	
	J. Medical ICU	15,109
	K. Pediatric ICU	
	L. Neuro ICU	
	M. Other	
	N. Other	
	O. Nursery	
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	1,815,123
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	774,036
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: 07/01/04 To: 06/30/05

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	1,041,087		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,041,087		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF 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)	1,041,087		

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: 07/01/04 To: 06/30/05

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 (BHF Page 7, Line 12)	774,036
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 (BHF 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**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/04 To: 06/30/05

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

	General Service	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III Sub III
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to BHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Unit	Sub III 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 BHF 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 BHF Page 4, Line 1)				

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 52-0098	Public Aid Provider Number: 13031
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/04 To: 06/30/05

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	72,901,891	175,000,918	0.416580
2.	Recovery Room			
3.	Delivery and Labor Room			
4.	Anesthesiology	13,220,005	39,429,204	0.335285
5.	Radiology - Diagnostic	49,262,779	177,866,549	0.276965
6.	Radiology - Therapeutic	7,894,146	31,300,327	0.252207
7.	Nuclear Medicine	3,494,992	7,236,661	0.482956
8.	Laboratory	41,956,621	116,458,779	0.360270
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	14,514,068	23,496,334	0.617716
13.	Physical Therapy			
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	25,934,917	63,680,620	0.407265
17.	EEG	1,524,884	5,316,626	0.286814
18.	Med. / Surg. Supplies	544,609	1,668,414	0.326423
19.	Drugs Charged to Patients	80,792,041	182,277,033	0.443238
20.	Renal Dialysis	2,372,825	5,356,563	0.442975
21.	Ambulance	3,473,034	7,553,182	0.459811
22.	Neuro Psych Testing	295,144	799,104	0.369344
23.	Rehab Services	17,247,710	25,474,114	0.677068
23.01	Pulmonary Function	1,306,190	3,754,654	0.347886
23.02	Orthotics Lab	1,747,256	2,993,979	0.583590
23.03	CSC Clinics	42,265,574	56,556,451	0.747317
23.04	Clinic U Station	10,701,438	10,555,493	1.013826
23.05	Clinic Waisman	439,057	396,600	1.107052
23.06	Clinic West	17,992,893	13,175,426	1.365640
23.07	Clinic East	8,530,332	6,867,669	1.242100
23.08	Clinic Research Park	4,090,878	6,203,477	0.659449
23.09	Other			
Outpatient Ancillary Centers				
24.	Clinic	2,665,726		
25.	Emergency	10,077,931	21,450,046	0.469833
26.	Observation	1,258,656		
Routine Service Cost Centers				
27.	Adults and Pediatrics	109,731,956	95,593	1,147.91
28.	Psychiatric Unit	5,453,530	5,207	1,047.35
29.	Rehabilitation Unit	5,118,925	6,076	842.48
30.	Sub III			
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Trauma ICU	14,195,231	7,329	1,936.86
34.	Burn ICU	3,875,311	1,858	2,085.74
35.	Surgical ICU	4,491,263	2,127	2,111.55
35.01	Medical ICU	3,490,181	1,589	2,196.46
35.02	Pediatric ICU	6,745,410	3,074	2,194.34
35.03	Neuro ICU	4,191,990	3,112	1,347.04
35.04	Other			
35.05	Other			
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: 07/01/04 To: 06/30/05

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	391		391
Newborn Days			
Total Inpatient Revenue	1,815,123		1,815,123
Ancillary Revenue	1,336,767		1,336,767
Routine Revenue	478,356		478,356
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 2 charges are greater than W/S C charges for Nuclear Medicine, Respiratory Therapy, Renal Dialysis, Clinic East, and ER.
- Adjusted Total Beds Available for Adults and Peds and Medical ICU to match W/S S-3, Pt. 1, Col. 1.
- Adjusted Total Bed Days Available for Adults and Peds and Medical ICU to match W/S S-3.
- Included the 21 program days with Adults and Peds, per Brad Hermann.
- Filed OHF Supplement 2 charges are less than W/S C charges for Pulmonary Function, CSC Clinic, and Clinic U Station.