

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

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 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 07/01/05 and ending 06/30/06 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

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

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

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

Hospital Statement of Cost / Statistical Data

PRELIMINARY

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

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	352	128,480		96,241	74.91%		21,548	5.36	
2.	Psychiatric Unit	20	7,300		4,982	68.25%		860	5.79	
3.	Rehabilitation Unit	21	7,665		5,966	77.83%		372	16.04	
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU	24	8,760		7,418	84.68%				
8.	Burn ICU	7	2,555		2,000	78.28%				
9.	Surgical ICU	8	2,920		2,131	72.98%				
10.	Medical ICU	7	2,555		1,652	64.66%				
11.	Pediatric ICU	18	6,570		2,823	42.97%				
12.	Neuro ICU	10	3,650		3,339	91.48%				
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total	467	170,455		126,552	74.24%		22,780	5.56	
17.	Observation Bed Days				1,284					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				100			62	10.76	
2.	Psychiatric Unit									
3.	Rehabilitation Unit									
4.	Sub III									
5.	Intensive Care Unit									
6.	Coronary Care Unit									
7.	Trauma ICU				334					
8.	Burn ICU				111					
9.	Surgical ICU				15					
10.	Medical ICU				50					
11.	Pediatric ICU									
12.	Neuro ICU				57					
13.	Other									
14.	Other									
15.	Newborn Nursery									
16.	Total				667	0.53%		62	10.76	

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

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	0.402806	704,458			283,760		
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	0.306204	145,469			44,543		
5.	Radiology - Diagnostic	0.259241	315,738			81,852		
6.	Radiology - Therapeutic	0.258413	6,968			1,801		
7.	Nuclear Medicine	0.449778	3,804			1,711		
8.	Laboratory	0.350629	308,137			108,042		
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.524209	95,487			50,055		
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	0.368149	195,757			72,068		
17.	EEG	0.248597	10,105			2,512		
18.	Med. / Surg. Supplies	0.372745	7,333			2,733		
19.	Drugs Charged to Patients	0.466134	416,679			194,228		
20.	Renal Dialysis	0.484284	20,350			9,855		
21.	Ambulance	0.634838						
22.	Neuro Psych Testing	0.421065	269			113		
23.	Rehab Services	0.600669	66,870			40,167		
23.01	Pulmonary Function	0.326556	1,602			523		
23.02	Orthotics Lab	0.797329	3,262			2,601		
23.03	CSC Clinics	0.741108	21,134			15,663		
23.04	Clinic U Station	1.048007	370			388		
23.05	Clinic Waisman	0.804335						
23.06	Clinic West	1.360796	1,108			1,508		
23.07	Clinic East	1.327684	93			123		
23.08	Clinic Research Park	0.711246	42			30		
23.09	Other							
Outpatient Service Cost Centers								
24.	Clinic							
25.	Emergency	0.485644	54,505			26,470		
26.	Observation							
27.	Total		2,379,540			940,746		

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

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)	\$ 1,234.78	\$ 1,148.19	\$ 946.79	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	100			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 123,478	\$	\$	\$
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)	\$ 123,478	\$	\$	\$

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	\$ 1,977.33	334	\$ 660,428
11.	Burn ICU	\$ 2,126.79	111	\$ 236,074
12.	Surgical ICU	\$ 2,989.12	15	\$ 44,837
13.	Medical ICU	\$ 2,184.44	50	\$ 109,222
14.	Pediatric ICU	\$ 2,404.27		\$
15.	Neuro ICU	\$ 1,458.08	57	\$ 83,111
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$		\$
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 940,746
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 2,197,896

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

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (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: 07/01/05 To: 06/30/06

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (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: 07/01/05 To: 06/30/06

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			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)	2,197,896		
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)	2,197,896		
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)	2,379,540
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	495,092
	B. Psychiatric Unit	
	C. Rehabilitation Unit	
	D. Sub III	
	E. Intensive Care Unit	
	F. Coronary Care Unit	
	G. Trauma ICU	434,200
	H. Burn ICU	144,300
	I. Surgical ICU	19,500
	J. Medical ICU	65,000
	K. Pediatric ICU	
	L. Neuro ICU	74,100
	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)	3,611,732
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	1,413,836
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: 07/01/05 To: 06/30/06

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)	2,197,896		
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)	2,197,896		
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)	2,197,896		

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

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

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 12)	1,413,836
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: 07/01/05 To: 06/30/06

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

	General Service	Sub I Psychiatric 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: 07/01/05 To: 06/30/06

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room	80,452,575	199,730,127	0.402806
2.	Recovery Room			
3.	Delivery and Labor Room			
4.	Anesthesiology	13,165,291	42,995,129	0.306204
5.	Radiology - Diagnostic	51,875,291	200,104,573	0.259241
6.	Radiology - Therapeutic	8,556,771	33,112,813	0.258413
7.	Nuclear Medicine	3,039,310	6,757,352	0.449778
8.	Laboratory	44,434,791	126,728,787	0.350629
9.	Blood			
10.	Blood - Administration			
11.	Intravenous Therapy			
12.	Respiratory Therapy	14,878,983	28,383,692	0.524209
13.	Physical Therapy			
14.	Occupational Therapy			
15.	Speech Pathology			
16.	EKG	26,148,009	71,025,627	0.368149
17.	EEG	1,491,584	6,000,009	0.248597
18.	Med. / Surg. Supplies	631,033	1,692,935	0.372745
19.	Drugs Charged to Patients	90,684,654	194,546,317	0.466134
20.	Renal Dialysis	2,426,749	5,011,008	0.484284
21.	Ambulance	5,008,792	7,889,872	0.634838
22.	Neuro Psych Testing	366,896	871,352	0.421065
23.	Rehab Services	18,816,594	31,326,049	0.600669
23.01	Pulmonary Function	1,500,030	4,593,490	0.326556
23.02	Orthotics Lab	1,957,964	2,455,653	0.797329
23.03	CSC Clinics	46,779,367	63,120,814	0.741108
23.04	Clinic U Station	11,697,528	11,161,687	1.048007
23.05	Clinic Waisman	359,102	446,458	0.804335
23.06	Clinic West	19,044,583	13,995,183	1.360796
23.07	Clinic East	9,558,477	7,199,359	1.327684
23.08	Clinic Research Park	4,502,923	6,331,031	0.711246
23.09	Other			
Outpatient Ancillary Centers				
24.	Clinic			
25.	Emergency	11,926,065	24,557,200	0.485644
26.	Observation			
Routine Service Cost Centers				
			Total Days	Per Diem
27.	Adults and Pediatrics	120,422,106	97,525	1,234.78
28.	Psychiatric Unit	5,720,271	4,982	1,148.19
29.	Rehabilitation Unit	5,648,571	5,966	946.79
30.	Sub III			
31.	Intensive Care Unit			
32.	Coronary Care Unit			
33.	Trauma ICU	14,667,840	7,418	1,977.33
34.	Burn ICU	4,253,574	2,000	2,126.79
35.	Surgical ICU	6,369,815	2,131	2,989.12
35.01	Medical ICU	3,608,701	1,652	2,184.44
35.02	Pediatric ICU	6,787,259	2,823	2,404.27
35.03	Neuro ICU	4,868,513	3,339	1,458.08
35.04	Other			
35.05	Other			
36.	Nursery			

