Hospital Statement of Cost

Healthcare and Family Services, 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			**Medicaid Provider Number:** 13031
City: Madison	**State:** Wisconsin	**Zip:** 53792	
Period Covered by Statement:	**From:** 07/01/2009	**To:** 06/30/2010	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual	XXXX XXXX	State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

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

XXXX XXXX	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
	Medicaid Sub I		Medicaid Sub III		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 07/01/2009 and ending 06/30/2010 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 Healthcare and Family Services 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:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	361	131,628		103,622	78.72%		24,446	5.13
2.	Psychiatric Unit	18	6,568		4,943	75.26%		991	4.99
3.	Rehabilitation Unit	21	7,651		6,432	84.07%		399	16.12
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,245	82.71%			
8.	Burn ICU	7	2,555		1,958	76.63%			
9.	Surgical ICU	8	2,920		1,990	68.15%			
10.	Medical ICU	7	2,555		1,600	62.62%			
11.	Pediatric ICU	21	7,663		4,213	54.98%			
12.	Neuro ICU	16	5,840		4,814	82.43%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**483**	**176,140**		**136,817**	**77.68%**		**25,836**	**5.30**
23.	Observation Bed Days				2,277				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,204				
2.	Psychiatric Unit								
3.	Rehabilitation Unit								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				133				
8.	Burn ICU				20				
9.	Surgical ICU				20				
10.	Medical ICU								
11.	Pediatric ICU				163				
12.	Neuro ICU				48				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**1,588**	**1.16%**			

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	690	935,251

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	96,885,309	264,968,135	0.365649	2,040,719	196,784	746,187	71,954
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	11,605,992	63,390,109	0.183088	468,817	52,447	85,835	9,602
5.	Radiology - Diagnostic	56,438,762	282,045,192	0.200105	892,689	568,012	178,632	113,662
6.	Radiology - Therapeutic	11,566,928	59,408,589	0.194701	28,646	164,345	5,577	31,998
7.	Nuclear Medicine	4,387,579	10,081,463	0.435213	10,195	26,393	4,437	11,487
8.	Laboratory	54,956,061	188,273,078	0.291895	958,514	277,464	279,785	80,990
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	18,329,842	32,819,624	0.558502	256,294	23,348	143,141	13,040
13.	Physical Therapy	27,026,656	54,283,860	0.497876	257,737	85,224	128,321	42,431
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	28,063,628	96,100,689	0.292023	491,550	140,983	143,544	41,170
17.	EEG	2,503,240	7,504,759	0.333554	24,717	14,844	8,244	4,951
18.	Med. / Surg. Supplies	27,189,175	44,926,088	0.605198	390,173	20,629	236,132	12,485
19.	Drugs Charged to Patients	135,459,185	283,177,326	0.478355	1,222,760	478,725	584,913	229,000
20.	Renal Dialysis	3,709,259	5,550,757	0.668244	47,340	2,829	31,635	1,890
21.	Ambulance	5,117,137	10,850,531	0.471602	110	31,453	52	14,833
22.	Pulmonary Function	725,724	2,433,973	0.298164	3,667	6,034	1,093	1,799
23.	Orthotics Lab	2,608,391	3,108,233	0.839188	9,340	6,399	7,838	5,370
24.	CSC Clinic	71,728,730	90,647,383	0.791294	69,000	243,669	54,599	192,814
25.	Clinic U Station	16,752,148	15,623,456	1.072243	657	45,148	704	48,410
26.	Clinic Waisman	1,629,728	1,390,671	1.171900	21	4,029	25	4,722
27.	Clinic West	25,704,140	18,663,468	1.377244	3,655	53,129	5,034	73,172
28.	Clinic East	14,232,302	11,170,388	1.274110	154	32,369	196	41,242
29.	Clinic Research Park	6,088,196	5,454,527	1.116173	28	15,819	31	17,657
30.	Neuropsych Testing	516,678	1,312,147	0.393765	777	3,589	306	1,413
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	16,173,965	47,912,281	0.337575	243,629	70,693	82,243	23,864
45.	Observation							
46.	**Total**				**7,421,189**	**2,564,358**	**2,728,504**	**1,089,956**

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 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:	Medicaid Provider Number:			
52-0098	13031			
Program:	**Period Covered by Statement:**			
Medicaid-Hospital	From:	07/01/2009	To:	06/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Un	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	120,309,846	4,910,723	6,825,297	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	105,899	4,943	6,432	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,136.08	993.47	1,061.15	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,204			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,367,840			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
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)	1,367,840			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit					
9.	Coronary Care Unit					
10.	Trauma ICU	19,927,897	7,245	2,750.57	133	365,826
11.	Burn ICU	5,025,143	1,958	2,566.47	20	51,329
12.	Surgical ICU	12,730,212	1,990	6,397.09	20	127,942
13.	Medical ICU	4,642,704	1,600	2,901.69		
14.	Pediatric ICU	11,048,986	4,213	2,622.59	163	427,482
15.	Neuro ICU	9,739,979	4,814	2,023.26	48	97,116
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,728,504
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,166,039**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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						
11.	Medical ICU						
12.	Pediatric ICU						
13.	Neuro ICU						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	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.	Pulmonary Function							
23.	Orthotics Lab							
24.	CSC Clinic							
25.	Clinic U Station							
26.	Clinic Waisman							
27.	Clinic West							
28.	Clinic East							
29.	Clinic Research Park							
30.	Neuropsych Testing							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary 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 / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics							
48.	Psychiatric Unit							
49.	Rehabilitation Unit							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Burn ICU							
55.	Surgical ICU							
56.	Medical ICU							
57.	Pediatric ICU							
58.	Neuro ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		1,089,956
2.	Inpatient Operating Services (BHF Page 4, Line 25)	5,166,039	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	399,198	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**5,565,237**	**1,089,956**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	84.00%	16.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	7,421,189	2,564,358
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,674,527	
	B. Psychiatric Unit		
	C. Rehabilitation Unit		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU	514,736	
	H. Burn ICU	67,669	
	I. Surgical ICU	48,251	
	J. Medical ICU		
	K. Pediatric ICU	909,622	
	L. Neuro ICU	208,246	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	10,844,240	2,564,358
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,753,405
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	5,565,237	1,089,956
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,565,237	1,089,956
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Sec. 115.2 (B)		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**5,565,237**	**1,089,956**

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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 13)	6,753,405
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
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 14)					
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		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
52-0098	**13031**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2009 To: 06/30/2010**

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 (CMS 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 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 Sub III**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
7.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, W/S D-1, Part I, Line 27) 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 cost differential) (CMS 2552, W/S D-1, Part I, Line 37)				
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 Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number: 52-0098	**Medicaid Provider Number:** 13031
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary 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.	Pulmonary Function							
23.	Orthotics Lab							
24.	CSC Clinic							
25.	Clinic U Station							
26.	Clinic Waisman							
27.	Clinic West							
28.	Clinic East							
29.	Clinic Research Park							
30.	Neuropsych Testing							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary 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 G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	35,111,807	105,899	331.56	1,204		399,198	
48.	Psychiatric Unit	2,003,716	4,943	405.36				
49.	Rehabilitation Unit	601,222	6,432	93.47				
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Burn ICU							
55.	Surgical ICU							
56.	Medical ICU							
57.	Pediatric ICU							
58.	Neuro ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**399,198**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**399,198**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,588		1,588
Newborn Days			
Total Inpatient Revenue	9,227,474	1,616,766	10,844,240
Ancillary Revenue	7,425,086	(3,897)	7,421,189
Routine Revenue	1,802,388	1,620,663	3,423,051
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	690		690
Total Outpatient Revenue	2,568,708	(4,350)	2,564,358
Outpatient Received and Receivable			

Notes:

Hospital categorized as Government-State based on filed S-2.
Observation Days were taken from filed S-3.
BHF Page 2 - Included the 8 Psych and 32 Rehab Days in filed report with Acute Adults & Peds.
BHF Page 7 - Included $53,864 of Psych/Rehab Routine Charges in filed report with Acute Adults & Peds.
Adjusted BHF Page 3 Costs to match filed W/S C.
GME Costs were adjusted to filed W/S B, Pt 1, Col 26.
Removed Medicaid Cardiac Rehab charges of $3,897 I/P and $4,350 O/P as those costs are non-allowable for Illinois Medicaid.
Per hospital, additional $1,620,663 Adults & Peds charges should be included.