

Hospital Statement of Cost

BHF Page 1

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: 07/01/2010	To: 06/30/2011

Type of Control

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

Type of Hospital

☐ 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)

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ 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 07/01/2010 and ending 06/30/2011 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	
Email Address	

Name (Typewritten)

Title
Date
Telephone Number
Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). 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

BHF Page 2

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	368	134,344		105,493	78.52%	25,479	25,388	5.01
2.	Psych	18	6,570		5,537	84.28%	936	997	5.55
3.	Rehab	21	7,665		5,860	76.45%	382	378	15.50
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,578	86.51%			
8.	Cardio Surgery ICU	8	2,920		1,777	60.86%			
9.	Cardiac ICU	7	2,555		1,608	62.94%			
10.	Pediatric ICU	21	7,665		4,349	56.74%			
11.	Neuro ICU	16	5,840		4,558	78.05%			
12.	Burn ICU	7	2,531		1,957	77.32%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	490	178,850		138,717	77.56%	26,797	26,763	5.18
23.	Observation Bed Days				3,451				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				767		249	249	6.22
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				278				
8.	Cardio Surgery ICU				60				
9.	Cardiac ICU				20				
10.	Pediatric ICU				296				
11.	Neuro ICU				91				
12.	Burn ICU				38				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				1,550	1.12%	249	249	6.22

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	2,433	928,762

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

BHF Page 3

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
52-0098		13031	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2010	To: 06/30/2011

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, 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	108,559,468	319,437,210	0.339846	1,718,086	683,662	583,885	232,340
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	11,908,811	71,995,000	0.165412	391,040	213,695	64,683	35,348
5.	Radiology - Diagnostic	39,549,741	114,464,105	0.345521	553,137	339,954	191,120	117,461
6.	Radiology - Therapeutic	11,491,444	55,851,409	0.205750	10,495	60,989	2,159	12,548
7.	Nuclear Medicine	4,545,673	12,421,775	0.365944	31,846	38,631	11,654	14,137
8.	Laboratory	55,896,391	215,158,125	0.259792	1,292,942	425,997	335,896	110,671
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,061,875	36,466,987	0.522716	1,011,325	4,672	528,636	2,442
13.	Physical Therapy	28,640,339	57,526,816	0.497861	236,006	40,114	117,498	19,971
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	27,515,688	105,951,926	0.259700	222,171	208,785	57,698	54,221
17.	EEG	2,501,535	8,033,654	0.311382	47,771	16,734	14,875	5,211
18.	Med. / Surg. Supplies	1,010,517	1,750,786	0.577179	98,843	7,637	57,050	4,408
19.	Drugs Charged to Patients	145,944,515	310,426,811	0.470141	1,511,695	578,435	710,710	271,946
20.	Renal Dialysis	3,809,195	5,613,419	0.678587	45,212	14,193	30,680	9,631
21.	Ambulance	4,949,798	11,991,156	0.412787		223,850		92,402
22.	CT Scan	7,980,541	105,759,159	0.075460	246,796	196,298	18,623	14,813
23.	MRI	10,036,344	92,262,153	0.108781	195,974	259,878	21,318	28,270
24.	Cardiac Rehab	1,609,768	1,856,623	0.867041				
25.	Neuropsych Testing	561,952	1,467,286	0.382987	537	516	206	198
26.	Clinic - CSC	76,128,563	97,039,572	0.784510	54,216	492,653	42,533	386,491
27.	Clinic - University Station	16,779,626	15,854,232	1.058369		49,540		52,432
28.	Clinic - Waisman	1,137,782	1,219,966	0.932634		10,780		10,054
29.	Clinic - West	29,555,380	25,624,736	1.153393	3,729	19,982	4,301	23,047
30.	Clinic - East	15,745,264	13,343,416	1.180002		8,655		10,213
31.	Clinic - Research Pk.	6,219,603	5,974,664	1.040996		4,557		4,744
32.	Pulmonary Function	757,512	2,642,619	0.286652	7,305	14,560	2,094	4,174
33.	Orthotics	2,301,923	2,942,684	0.782253	3,504	8,851	2,741	6,924
34.	Implant Devices	25,126,483	39,399,403	0.637738				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	17,082,626	61,461,533	0.277940	108,635	110,322	30,194	30,663
45.	Observation	3,950,705	10,815,572	0.365279		69,326		25,323
46.	Total				7,791,265	4,103,266	2,828,554	1,580,083

* 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

BHF Page 4

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	124,719,607	5,061,676	6,257,126	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	108,944	5,537	5,860	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,144.80	914.15	1,067.77	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	767			
3.	Program general inpatient routine cost (Line 1c X Line 2)	878,062			
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)	878,062			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit					
9.	Coronary Care Unit					
10.	Trauma ICU	19,890,284	7,578	2,624.74	278	729,678
11.	Cardio Surgery ICU	12,222,785	1,777	6,878.33	60	412,700
12.	Cardiac ICU	4,667,151	1,608	2,902.46	20	58,049
13.	Pediatric ICU	11,476,537	4,349	2,638.89	296	781,111
14.	Neuro ICU	10,887,769	4,558	2,388.72	91	217,374
15.	Burn ICU	4,978,444	1,957	2,543.92	38	96,669
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)					2,828,554
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					6,002,197

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	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Trauma ICU						
9.	Cardio Surgery ICU						
10.	Cardiac ICU						
11.	Pediatric ICU						
12.	Neuro ICU						
13.	Burn 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	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)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, 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.	CT Scan							
23.	MRI							
24.	Cardiac Rehab							
25.	Neuropsych Testing							
26.	Clinic - CSC							
27.	Clinic - University Station							
28.	Clinic - Waisman							
29.	Clinic - West							
30.	Clinic - East							
31.	Clinic - Research Pk.							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implant Devices							
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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Burn 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)							

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

BHF Page 7

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			1,580,083
2. Inpatient Operating Services (BHF Page 4, Line 25)	6,002,197		
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)	254,422		
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	6,256,619		1,580,083
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	80.00%		20.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		7,791,265	4,103,266
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics	2,221,548		
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. Trauma ICU	471,297		
H. Cardio Surgery ICU	44,545		
I. Cardiac ICU	37,205		
J. Pediatric ICU	1,170,162		
K. Neuro ICU	163,110		
L. Burn ICU	146,980		
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)	12,046,112		4,103,266
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			8,312,676
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

BHF Page 8

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	6,256,619	1,580,083
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,256,619	1,580,083
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, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	6,256,619	1,580,083

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

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	8,312,676
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)	(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
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 Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(A)	General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B)	Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C)	Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
(A)	Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B)	Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, 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 2552-10, 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 1c)				

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: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, 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.	CT Scan							
23.	MRI							
24.	Cardiac Rehab							
25.	Neuropsych Testing							
26.	Clinic - CSC							
27.	Clinic - University Station							
28.	Clinic - Waisman							
29.	Clinic - West							
30.	Clinic - East							
31.	Clinic - Research Pk.							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implant Devices							
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:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	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	36,137,456	108,944	331.71	767		254,422	
48.	Psych	2,073,143	5,537	374.42				
49.	Rehab	596,691	5,860	101.82				
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Burn ICU							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						254,422	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						254,422	

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,550		1,550
Newborn Days			
Total Inpatient Revenue	12,265,619	(219,507)	12,046,112
Ancillary Revenue	8,010,772	(219,507)	7,791,265
Routine Revenue	4,254,847		4,254,847
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	2,433		2,433
Total Outpatient Revenue	3,885,505	217,761	4,103,266
Outpatient Received and Receivable			

Notes:

[illegible]