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 Hospitals 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:** 07/01/2022	**To:** 06/30/2023

Type of Control

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

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 Rehab		
	Medicaid Sub I Psych		Medicaid Sub III Other		

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 07/01/2022 and ending 06/30/2023 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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	513	185,678		149,192	80.35%		28,979	6.37
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,980	91.10%			
8.	Cardio Surgery ICU	27	6,676		6,177	92.53%			
9.	Cardiac ICU	4	1,309		1,008	77.01%			
10.	Pediatric ICU	21	7,665		5,057	65.98%			
11.	Neuro ICU	18	6,570		5,989	91.16%			
12.	Neonatal ICU	26	9,490		5,741	60.50%			
13.	Burn ICU	11	4,015		3,396	84.58%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**644**	**230,163**		**184,540**	**80.18%**		**28,979**	**6.37**
23.	Observation Bed Days				7,686				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				491			75	10.03
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				19				
8.	Cardio Surgery ICU				71				
9.	Cardiac ICU								
10.	Pediatric ICU				146				
11.	Neuro ICU				25				
12.	Neonatal ICU								
13.	Burn ICU								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**752**	**0.41%**		**75**	**10.03**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	454	961,506

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: 07/01/2022 To: 06/30/2023

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	127,842,361	867,345,228	0.147395	1,866,487	423,757	275,111	62,460
2.	Recovery Room	46,237,707	149,203,132	0.309898	88,306	110,552	27,366	34,260
3.	Delivery and Labor Room							
4.	Anesthesiology	18,261,795	79,838,947	0.228733	120,115	30,471	27,474	6,970
5.	Radiology - Diagnostic	47,352,502	282,172,401	0.167814	260,028	133,714	43,636	22,439
6.	Radiology - Therapeutic	16,832,025	236,192,206	0.071264		220		16
7.	Nuclear Medicine	17,031,752	48,939,388	0.348017				
8.	Laboratory	87,152,486	763,216,206	0.114191	942,003	170,838	107,568	19,508
9.	Blood							
10.	Blood - Administration	17,989,288	48,169,701	0.373457	163,344		61,002	
11.	Intravenous Therapy							
12.	Respiratory Therapy	30,338,674	135,084,449	0.224590	1,416,507	27,179	318,133	6,104
13.	Physical Therapy	36,054,606	115,562,284	0.311993	161,412	9,917	50,359	3,094
14.	Occupational Therapy							
15.	Speech Pathology	7,005,271	22,959,483	0.305114	104,792	4,060	31,974	1,239
16.	EKG	27,666,604	251,928,073	0.109819	302,674	56,369	33,239	6,190
17.	EEG	7,348,837	37,646,748	0.195205	201,970	4,137	39,426	808
18.	Med. / Surg. Supplies	99,634,142	255,889,983	0.389363	410,930	5,580	160,001	2,173
19.	Drugs Charged to Patients	258,575,536	##########	0.207906	1,567,086	230,318	325,807	47,884
20.	Renal Dialysis	6,193,307	15,085,130	0.410557	49,021		20,126	
21.	Ambulance	23,775,719	35,764,430	0.664787	370,830	73,996	246,523	49,192
22.	CT Scan	11,885,176	327,482,181	0.036293	205,733	70,449	7,467	2,557
23.	MRI	14,308,941	283,582,970	0.050458	217,118	52,071	10,955	2,627
24.	Cardiac Rehab	1,623,655	5,081,875	0.319499				
25.	Neuropsych Testing	1,424,148	1,685,368	0.845007				
26.	Clinic-Univ Hosp & AFCH	149,397,013	197,850,834	0.755099	136,357	111,734	102,963	84,370
27.	Clinic-University Station	12,634,735	25,947,142	0.486941		18,995		9,249
28.	Clinic-Waisman	4,060,765	2,113,479	1.921365		6,606		12,693
29.	Clinic-Junction West	27,449,854	44,839,885	0.612175		6,523		3,993
30.	Clinic-East Terrace	14,474,454	25,914,751	0.558541		1,978		1,105
31.	Clinic-Science	6,146,638	10,206,726	0.602214		3,745		2,255
32.	Pulmonary Function	1,783,097	9,563,465	0.186449		1,506		281
33.	Orthotics	5,523,639	14,109,705	0.391478				
34.	Implantable Devices	41,564,907	100,630,064	0.413047	31,301	1,920	12,929	793
35.	Clinic-DHC	20,821,812	126,108,040	0.165111		4,022		664
36.	Clinic -East Madison	19,674,277	28,243,247	0.696601		7,762		5,407
37.	Clinic-Womens Pelvic	1,464,046	2,431,953	0.602004		966		582
38.	Clinic-2775 Deming Way	3,443,219	2,707,611	1.271682		7,848		9,980
39.	Clinic-Univ Rehab Middleton	795,534	3,054,486	0.260448				
40.	Clinic-Behavioral Health	573,888	1,160,201	0.494645				
41.	Clinic-Kidney	1,276,630	1,257,267	1.015401				
42.	Clinic-1102 S Park Pain	3,405,058	9,028,297	0.377154		220		83
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	67,106,709	303,480,264	0.221124	216,306	71,464	47,830	15,802
45.	Observation	13,593,998	61,699,717	0.220325				
46.	**Total**				**8,832,320**	**1,648,917**	**1,949,889**	**414,778**

* 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: 07/01/2022 To: 06/30/2023

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)	277,465,624			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	156,878			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,768.67			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	491			
3.	Program general inpatient routine cost (Line 1c X Line 2)	868,417			
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)	868,417			

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	27,582,886	7,980	3,456.50	19	65,674
11.	Cardio Surgery ICU	18,514,066	6,177	2,997.26	71	212,805
12.	Cardiac ICU	3,729,843	1,008	3,700.24		
13.	Pediatric ICU	16,498,219	5,057	3,262.45	146	476,318
14.	Neuro ICU	18,574,526	5,989	3,101.44	25	77,536
15.	Neonatal ICU	13,884,674	5,741	2,418.51		
16.	Burn ICU	12,887,972	3,396	3,795.04		
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)					1,949,889
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**3,650,639**

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: 07/01/2022 To: 06/30/2023

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Neonatal ICU						
14.	Burn ICU						
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 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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: 07/01/2022 To: 06/30/2023

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-Univ Hosp & AFCH							
27.	Clinic-University Station							
28.	Clinic-Waisman							
29.	Clinic-Junction West							
30.	Clinic-East Terrace							
31.	Clinic-Science							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implantable Devices							
35.	Clinic-DHC							
36.	Clinic -East Madison							
37.	Clinic-Womens Pelvic							
38.	Clinic-2775 Deming Way							
39.	Clinic-Univ Rehab Middleton							
40.	Clinic-Behavioral Health							
41.	Clinic-Kidney							
42.	Clinic-1102 S Park Pain							
	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: 07/01/2022 To: 06/30/2023

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.	Neonatal ICU							
59.	Burn ICU							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		414,778
2.	Inpatient Operating Services (BHF Page 4, Line 25)	3,650,639	
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)	248,750	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**3,899,389**	**414,778**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	90.00%	10.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	8,832,320	1,648,917
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,497,071	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU	186,327	
	H. Cardio Surgery ICU	578,070	
	I. Cardiac ICU		
	J. Pediatric ICU	1,559,625	
	K. Neuro ICU	243,260	
	L. Neonatal ICU		
	M. Burn ICU		
	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)**	13,896,673	1,648,917
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		11,231,423
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: 07/01/2022 To: 06/30/2023

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)	3,899,389	414,778
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,899,389	414,778
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)**	**3,899,389**	**414,778**

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.

Rev. 10 / 11

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: 07/01/2022 To: 06/30/2023

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)	11,231,423
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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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

	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1.					
	(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:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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-Univ Hosp & AFCH							
27.	Clinic-University Station							
28.	Clinic-Waisman							
29.	Clinic-Junction West							
30.	Clinic-East Terrace							
31.	Clinic-Science							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implantable Devices							
35.	Clinic-DHC							
36.	Clinic -East Madison							
37.	Clinic-Womens Pelvic							
38.	Clinic-2775 Deming Way							
39.	Clinic-Univ Rehab Middleton							
40.	Clinic-Behavioral Health							
41.	Clinic-Kidney							
42.	Clinic-1102 S Park Pain							
	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: 07/01/2022 To: 06/30/2023

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	79,478,087	156,878	506.62	491		248,750	
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.	Neonatal ICU							
59.	Burn ICU							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**248,750**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**248,750**	

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: 07/01/2022	To:	06/30/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	752		752
Newborn Days			
Total Inpatient Revenue	14,009,583	(112,910)	13,896,673
Ancillary Revenue	8,832,980	(660)	8,832,320
Routine Revenue	5,176,603	(112,250)	5,064,353
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	454		454
Total Outpatient Revenue	1,648,915	2	1,648,917
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Reclassified 4 Beds Available from A&P to Cardiac ICU; The Total Beds Available for Cardiac ICU divided by 365 days in the reporting period are 4 Beds Available; no bed reported for CICU on as-filed cost report

BHF Page 2 - Included Obervation Days onto line 23 per W/S S-3 of the Medicare report

BHF Page 2 - Part I-Hospital Included the Observation days on line 23, col 4

BHF Page 2 - Adjusted the Part I-Hospital Discharges to agree with W/S S-3 of the Medicare report

BHF Page 2 - Did not allocate any nonDPU Psych beds and bed days to Part I-Hospital, line 2 as was done on past cost reports; W/S S-2 of the Medicare report state the hospital is not a Psych reporting hospital which agrees with the IPCR also

BHF Page 3 - Reclassified blood to blood admin

BHF Page 3 - Adjusted out Cardiac Rehab I/P charges as not allowable under IL Medicaid

BHF Page 4 - Added the observation days to line 1b of the A&P Column

BHF Page 7 - Adjusted out the Neonatal ICU as no program days for Neonatal ICU

BHF Supplemental 2a - These are only step down costs not intern costs; not included on the cost report

BHF Supplemental 2b - Added observation days to col 2, line 47

Minor rounding adjustment