

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
 FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
 (42 USC 1395g).

FORM APPROVED
 OMB NO. 0938-0050

WORKSHEET S
 PARTS I & II

| | | | | | | | | |
|--|--|--------------|--|----------------|--|-------------------------|--|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | | PROVIDER NO: | | PERIOD | | INTERMEDIARY USE ONLY | | DATE RECEIVED: |
| COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | | 52-3300 | | FROM 1/ 1/2008 | | --AUDITED --DESK REVIEW | | / / |
| | | | | TO 12/31/2008 | | --INITIAL --REOPENED | | INTERMEDIARY NO: |
| | | | | | | --FINAL 1-MCR CODE | | |
| | | | | | | 00 - # OF REOPENINGS | | |

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2009 TIME 8:22

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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 ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
 CHILDREN'S HOSPITAL OF WISCONSIN 52-3300
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 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. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 ECR ENCRYPTION INFORMATION
 DATE: 5/27/2009 TIME 8:22

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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 6CHQ10S9Mta61x03DSY6UPUn i HENI
 JNXR1. i vsG0FGquC

 TITLE

 PI ENCRYPTION INFORMATION
 DATE: 5/27/2009 TIME 8:22

 DATE

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 R50yW06BCQcomVETi YSN8DofbrsW3k
 L9Q188xos20Qw1QM

PART II - SETTLEMENT SUMMARY

| | TITLE V | A | TITLE XVIII | B | TITLE XIX |
|-----|------------|---|----------------|-------|--------------|
| | 1 | 2 | | 3 | 4 |
| 1 | HOSPITAL | 0 | 155,253 | 3,991 | 15,838,913 |
| 100 | TOTAL | 0 | 155,253 | 3,991 | 15,838,913 |

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.