

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 Iowa Hospital & Clinics		Medicare Provider Number: 16-0058	
Street: 200 Hawkins Drive		Medicaid Provider Number: 9003	
City: Iowa City	State: IA	Zip: 52242	
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 Iowa Hospital & 9003 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

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:	16-0058	Medicaid Provider Number:	9003
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	464	169,264		124,945	73.82%	27,854	27,854	6.17
2.	Psych	73	26,645		24,596	92.31%	2,091	2,091	11.76
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	36	13,140		10,671	81.21%			
6.	Coronary Care Unit	12	4,380		3,168	72.33%			
7.	Medical ICU	20	7,300		6,377	87.36%			
8.	Burn ICU	16	5,840		4,966	85.03%			
9.	Pediatric ICU	72	26,280		21,759	82.80%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,760		3,110	35.50%			
22.	Total	717	261,609		199,592	76.29%	29,945	29,945	6.56
23.	Observation Bed Days				3,106				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				258		81	80	6.89
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				242				
6.	Coronary Care Unit				4				
7.	Medical ICU				26				
8.	Burn ICU				2				
9.	Pediatric ICU				19				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				118				
22.	Total				669	0.34%	81	80	6.89

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	239	743,818

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

BHF Page 3

Preliminary

Medicare Provider Number: 16-0058			Medicaid Provider Number: 9003		
Program: Medicaid Hospital			Period Covered by Statement:		
			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	65,456,768	271,428,661	0.241156	560,808	190,312	135,242	45,895
2.	Recovery Room							
3.	Delivery and Labor Room	6,187,243	13,651,720	0.453221	20,764	1,596	9,411	723
4.	Anesthesiology	7,378,116	36,655,729	0.201281	63,175	21,052	12,716	4,237
5.	Radiology - Diagnostic	42,126,008	251,699,324	0.167366	308,166	168,873	51,577	28,264
6.	Radiology - Therapeutic	11,901,170	58,949,682	0.201887		1,905		385
7.	Nuclear Medicine							
8.	Laboratory	53,094,125	273,941,644	0.193815	462,306	74,621	89,602	14,463
9.	Blood							
10.	Blood - Administration	8,464,486	25,417,721	0.333015	128,077	1,530	42,652	510
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,877,523	36,576,278	0.215372	92,809	5,188	19,988	1,117
13.	Physical Therapy	5,330,478	13,505,099	0.394701	32,904	2,182	12,987	861
14.	Occupational Therapy	2,380,202	5,439,123	0.437608	20,122	354	8,806	155
15.	Speech Pathology							
16.	EKG	874,824	5,664,892	0.154429	30,563	53,915	4,720	8,326
17.	EEG	2,642,711	10,934,363	0.241689	6,054	1,709	1,463	413
18.	Med. / Surg. Supplies	28,294,693	59,919,152	0.472215	244,663	11,446	115,534	5,405
19.	Drugs Charged to Patients	102,614,023	202,494,394	0.506750	411,496	143,885	208,526	72,914
20.	Renal Dialysis	9,030,348	28,783,403	0.313735	39,081		12,261	
21.	Ambulance	5,180,208	14,364,238	0.360632				
22.	Ultrasound	3,586,475	19,749,723	0.181596				
23.	Cardiology	15,395,956	97,657,976	0.157652	4,841	25,792	763	4,066
24.	Orthotic Services	2,069,562	3,992,687	0.518338				
25.	Digestive Disease	7,158,920	31,252,484	0.229067	22,779	15,450	5,218	3,539
26.	Implants	59,275,727	119,991,217	0.494001				
27.	ASC	16,077,313	46,526,595	0.345551				
28.	Other	9,371,819	20,139,045	0.465356	15,382	3,109	7,158	1,447
29.	Kidney Acquisition	5,180,513	6,840,000	0.757385				
30.	Heart Acquisition	1,238,306	1,380,000	0.897323				
31.	Liver Acquisition	2,341,891	3,145,000	0.744639				
32.	Lung Acquisition	1,518,839	1,530,000	0.992705				
33.	Pancreas Acquisition	498,277	630,000	0.790916				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	93,816,298	128,505,276	0.730058	2,192	1,805	1,600	1,318
44.	Emergency	12,702,497	73,715,654	0.172317	75,355	58,020	12,985	9,998
45.	Observation	2,995,426	6,813,874	0.439607	990	9,572	435	4,208
46.	Total				2,542,527	792,316	753,644	208,244

* 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: 16-0058	Medicaid Provider Number: 9003
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)	123,492,150	19,398,437		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	128,051	24,596		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	964.40	788.68		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	258			
3.	Program general inpatient routine cost (Line 1c X Line 2)	248,815			
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)	248,815			

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	17,955,740	10,671	1,682.67	242	407,206
9.	Coronary Care Unit	5,422,834	3,168	1,711.75	4	6,847
10.	Medical ICU	10,717,476	6,377	1,680.65	26	43,697
11.	Burn ICU	7,892,260	4,966	1,589.26	2	3,179
12.	Pediatric ICU	26,356,892	21,759	1,211.31	19	23,015
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,163,135	3,110	695.54	118	82,074
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					753,644
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,568,477

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

Preliminary

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
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.	Medical ICU						
9.	Burn ICU						
10.	Pediatric ICU						
11.	Other						
12.	Other						
13.	Other						
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:	16-0058	Medicaid Provider Number:	9003
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.	Ultrasound							
23.	Cardiology							
24.	Orthotic Services							
25.	Digestive Disease							
26.	Implants							
27.	ASC							
28.	Other							
29.	Kidney Acquisition							
30.	Heart Acquisition							
31.	Liver Acquisition							
32.	Lung Acquisition							
33.	Pancreas Acquisition							
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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
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.	Medical ICU							
54.	Burn ICU							
55.	Pediatric ICU							
56.	Other							
57.	Other							
58.	Other							
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: 16-0058	Medicaid Provider Number: 9003
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)			208,244
2. Inpatient Operating Services (BHF Page 4, Line 25)		1,568,477	
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)		82,752	14,512
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,651,229	222,756
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		88.00%	12.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		2,542,527	792,316
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		1,548,485	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. Medical ICU			
H. Burn ICU			
I. Pediatric ICU			
J. Other			
K. Other			
L. Other			
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)		4,091,012	792,316
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			3,009,343
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: 16-0058	Medicaid Provider Number: 9003
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)	1,651,229	222,756
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,651,229	222,756
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)	1,651,229	222,756

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:	16-0058	Medicaid Provider Number:	9003
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)	3,009,343
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: 16-0058	Medicaid Provider Number: 9003
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:	16-0058	Medicaid Provider Number:	9003
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	5,437,204	271,428,661	0.020032	560,808	190,312	11,234	3,812
2.	Recovery Room							
3.	Delivery and Labor Room	669,836	13,651,720	0.049066	20,764	1,596	1,019	78
4.	Anesthesiology	7,654,973	36,655,729	0.208834	63,175	21,052	13,193	4,396
5.	Radiology - Diagnostic	4,188,852	251,699,324	0.016642	308,166	168,873	5,128	2,810
6.	Radiology - Therapeutic	736,745	58,949,682	0.012498		1,905		24
7.	Nuclear Medicine							
8.	Laboratory	2,824,012	273,941,644	0.010309	462,306	74,621	4,766	769
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	11,302	5,664,892	0.001995	30,563	53,915	61	108
17.	EEG	224,083	10,934,363	0.020493	6,054	1,709	124	35
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	757,910	28,783,403	0.026331	39,081		1,029	
21.	Ambulance							
22.	Ultrasound	462,029	19,749,723	0.023394				
23.	Cardiology	9,795	97,657,976	0.000100	4,841	25,792		3
24.	Orthotic Services							
25.	Digestive Disease	63,593	31,252,484	0.002035	22,779	15,450	46	31
26.	Implants							
27.	ASC							
28.	Other	135,022	20,139,045	0.006704	15,382	3,109	103	21
29.	Kidney Acquisition							
30.	Heart Acquisition							
31.	Liver Acquisition							
32.	Lung Acquisition							
33.	Pancreas Acquisition							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	20,085,000	128,505,276	0.156297	2,192	1,805	343	282
44.	Emergency	2,722,143	73,715,654	0.036928	75,355	58,020	2,783	2,143
45.	Observation							
46.	Ancillary Total						39,829	14,512

* 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:	16-0058	Medicaid Provider Number:	9003
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	8,715,708	128,051	68.06	258		17,559	
48.	Psych	1,516,438	24,596	61.65				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	700,427	10,671	65.64	242		15,885	
52.	Coronary Care Unit	699,523	3,168	220.81	4		883	
53.	Medical ICU	533,157	6,377	83.61	26		2,174	
54.	Burn ICU	207,205	4,966	41.72	2		83	
55.	Pediatric ICU	613,778	21,759	28.21	19		536	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	152,954	3,110	49.18	118		5,803	
67.	Routine Total (lines 47-66)						42,923	
68.	Ancillary Total (from line 46)						39,829	14,512
69.	Total (Lines 67-68)						82,752	14,512

Preliminary

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
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	551		551
Newborn Days	118		118
Total Inpatient Revenue	4,091,012		4,091,012
Ancillary Revenue	2,542,527		2,542,527
Routine Revenue	1,548,485		1,548,485
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	239		239
Total Outpatient Revenue	792,316		792,316
Outpatient Received and Receivable			

Notes:

[illegible]