

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: Iowa	Zip: 52242-1009	
Period Covered by Statement:	From: 07/01/2012	To: 06/30/2013	

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 07/01/2012 and ending 06/30/2013 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:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2012 To: 06/30/2013

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	453	165,345		121,533	73.50%	28,166	28,166	5.92
2.	Psych	73	26,645		25,622	96.16%	2,188	2,188	11.71
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit	11	4,015		2,964	73.82%			
7.	Medical ICU	26	9,490		6,643	70.00%			
8.	Burn ICU	15	5,475		4,708	85.99%			
9.	Surgical ICU	36	13,140		10,548	80.27%			
10.	Neonatal ICU	79	28,835		20,343	70.55%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,760		3,206	36.60%			
22.	Total	717	261,705		195,567	74.73%	30,354	30,354	6.34
23.	Observation Bed Days				4,352				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				267		71	71	9.17
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit				1				
7.	Medical ICU				6				
8.	Burn ICU								
9.	Surgical ICU				11				
10.	Neonatal ICU				366				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				10				
22.	Total				661	0.34%	71	71	9.17

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	258	857,187

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

BHF Page 3

Preliminary

Medicare Provider Number:				Medicaid Provider Number:			
16-0058				9003			
Program:				Period Covered by Statement:			
Medicaid Hospital				From:	07/01/2012	To:	06/30/2013

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	77,383,326	311,797,334	0.248185	413,603	244,498	102,650	60,681
2.	Recovery Room							
3.	Delivery and Labor Room	6,323,505	15,202,577	0.415950	34,188		14,220	
4.	Anesthesiology	8,319,573	47,855,218	0.173849	46,576	31,046	8,097	5,397
5.	Radiology - Diagnostic	44,189,903	301,476,935	0.146578	247,649	255,899	36,300	37,509
6.	Radiology - Therapeutic	11,016,931	69,026,910	0.159603	23,215	59,789	3,705	9,543
7.	Nuclear Medicine							
8.	Laboratory	52,754,023	316,919,646	0.166459	4,051	60,978	674	10,150
9.	Blood							
10.	Blood - Administration	7,261,487	25,242,285	0.287672	371,160	6,253	106,772	1,799
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,532,679	38,157,331	0.197411	185,855	3,936	36,690	777
13.	Physical Therapy	6,426,622	15,534,565	0.413698	12,780	885	5,287	366
14.	Occupational Therapy	2,403,143	5,955,841	0.403493	8,865	2,818	3,577	1,137
15.	Speech Pathology							
16.	EKG	903,866	6,295,915	0.143564	34,994	49,316	5,024	7,080
17.	EEG	3,423,766	15,125,086	0.226363	22,742	4,512	5,148	1,021
18.	Med. / Surg. Supplies	25,933,620	64,848,520	0.399911	153,768	29,307	61,494	11,720
19.	Drugs Charged to Patients	122,492,541	297,701,360	0.411461	268,187	107,830	110,348	44,368
20.	Renal Dialysis	9,551,160	32,932,372	0.290023	11,780		3,416	
21.	Ambulance	6,764,041	15,675,241	0.431511				
22.	Ultrasound	4,060,924	20,951,343	0.193826				
23.	Cardiology	18,444,104	108,960,786	0.169273		38,926		6,589
24.	Orthotic Services	3,704,237	8,744,952	0.423586				
25.	Digestive Disease	6,748,336	31,830,302	0.212010	1,840	5,078	390	1,077
26.	Implants	58,144,309	152,843,158	0.380418				
27.	ASC	15,886,783	61,466,868	0.258461				
28.	Other	9,889,782	26,068,608	0.379375	305	6,826	116	2,590
29.	Kidney Acquisition	5,285,479	11,816,750	0.447287				
30.	Heart Acquisition	1,309,267	2,912,000	0.449611				
31.	Liver Acquisition	2,276,982	4,386,500	0.519089				
32.	Lung Acquisition	1,316,551	2,472,000	0.532585				
33.	Pancreas Acquisition	641,780	648,000	0.990401				
34.	Bone Marrow Transpl.	2,821,992	6,026,652	0.468252				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	125,026,890	166,555,555	0.750662		343		257
44.	Emergency	13,134,080	88,912,747	0.147719	64,516	92,398	9,530	13,649
45.	Observation	4,505,800	10,740,744	0.419505	310	17,902	130	7,510
46.	Total				1,906,384	1,018,540	513,568	223,220

* 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: 07/01/2012 To: 06/30/2013

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)	130,333,617	21,541,094		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	125,885	25,622		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,035.34	840.73		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	267			
3.	Program general inpatient routine cost (Line 1c X Line 2)	276,436			
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)	276,436			

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	4,910,827	2,964	1,656.82	1	1,657
10.	Medical ICU	11,709,972	6,643	1,762.75	6	10,577
11.	Burn ICU	7,547,810	4,708	1,603.19		
12.	Surgical ICU	17,977,060	10,548	1,704.31	11	18,747
13.	Neonatal ICU	26,479,239	20,343	1,301.64	366	476,400
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,472,177	3,206	771.11	10	7,711
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					513,568
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,305,096

**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: 07/01/2012 To: 06/30/2013

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.	Surgical ICU						
11.	Neonatal ICU						
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	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2012 To: 06/30/2013

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.	Bone Marrow Transpl.							
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: 07/01/2012 To: 06/30/2013

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.	Surgical ICU							
56.	Neonatal ICU							
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: 07/01/2012 To: 06/30/2013

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			223,220
2. Inpatient Operating Services (BHF Page 4, Line 25)		1,305,096	
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)		68,481	21,636
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,373,577	244,856
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		85.00%	15.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9. Ancillary Services (See Instructions)		1,906,384	1,018,540
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		1,875,235	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. Medical ICU			
H. Burn ICU			
I. Surgical ICU			
J. Neonatal ICU			
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)		3,781,619	1,018,540
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			3,181,726
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: 07/01/2012 To: 06/30/2013

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)	1,373,577	244,856
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,373,577	244,856
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)	1,373,577	244,856

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: 07/01/2012 To: 06/30/2013

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)	3,181,726
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)	(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: 07/01/2012 To: 06/30/2013

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:		Medicaid Provider Number:	
16-0058		9003	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2012	To: 06/30/2013

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	6,903,081	311,797,334	0.022140	413,603	244,498	9,157	5,413
2.	Recovery Room							
3.	Delivery and Labor Room	850,425	15,202,577	0.055940	34,188		1,912	
4.	Anesthesiology	9,718,763	47,855,218	0.203087	46,576	31,046	9,459	6,305
5.	Radiology - Diagnostic	5,318,171	301,476,935	0.017640	247,649	255,899	4,369	4,514
6.	Radiology - Therapeutic	935,372	69,026,910	0.013551	23,215	59,789	315	810
7.	Nuclear Medicine							
8.	Laboratory	3,585,371	316,919,646	0.011313	4,051	60,978	46	690
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	14,350	6,295,915	0.002279	34,994	49,316	80	112
17.	EEG	284,496	15,125,086	0.018810	22,742	4,512	428	85
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	743,191	32,932,372	0.022567	11,780		266	
21.	Ambulance							
22.	Ultrasound	586,593	20,951,343	0.027998				
23.	Cardiology	12,436	108,960,786	0.000114		38,926		4
24.	Orthotic Services							
25.	Digestive Disease	80,738	31,830,302	0.002537	1,840	5,078	5	13
26.	Implants							
27.	ASC							
28.	Other	171,424	26,068,608	0.006576	305	6,826	2	45
29.	Kidney Acquisition							
30.	Heart Acquisition							
31.	Liver Acquisition							
32.	Lung Acquisition							
33.	Pancreas Acquisition							
34.	Bone Marrow Transpl.							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	25,499,937	166,555,555	0.153102		343		53
44.	Emergency	3,456,036	88,912,747	0.038870	64,516	92,398	2,508	3,592
45.	Observation							
46.	Ancillary Total						28,547	21,636

* 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: 07/01/2012 To: 06/30/2013

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	11,065,478	125,885	87.90	267		23,469	
48.	Psych	1,925,271	25,622	75.14				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	888,115	2,964	299.63	1		300	
53.	Medical ICU	676,896	6,643	101.90	6		611	
54.	Burn ICU	263,067	4,708	55.88				
55.	Surgical ICU	889,264	10,548	84.31	11		927	
56.	Neonatal ICU	779,253	20,343	38.31	366		14,021	
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	194,192	3,206	60.57	10		606	
67.	Routine Total (lines 47-66)						39,934	
68.	Ancillary Total (from line 46)						28,547	21,636
69.	Total (Lines 67-68)						68,481	21,636

Preliminary

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	651		651
Newborn Days	10		10
Total Inpatient Revenue	3,781,619		3,781,619
Ancillary Revenue	1,906,384		1,906,384
Routine Revenue	1,875,235		1,875,235
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	258		258
Total Outpatient Revenue	1,018,540		1,018,540
Outpatient Received and Receivable			

Notes:

[illegible]