

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 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: 07/01/2008	To: 06/30/2009

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> 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 & 19003 for the cost report beginning 07/01/2008 and ending 06/30/2009 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 _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	455	165,235		125,054	75.68%		27,309	6.19
2.	Psych	73	26,645		23,503	88.21%		2,229	10.54
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit	12	4,380		3,412	77.90%			
7.	Surgical ICU	36	12,832		11,120	86.66%			
8.	Medical ICU	20	5,662		4,811	84.97%			
9.	Burn ICU	16	5,840		5,031	86.15%			
10.	NICU	72	26,280		19,697	74.95%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,760		2,937	33.53%			
22.	Total	708	255,634		195,565	76.50%		29,538	6.52
23.	Observation Bed Days				1,978				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				260			122	4.10
2.	Psych								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit				6				
7.	Surgical ICU				181				
8.	Medical ICU				15				
9.	Burn ICU								
10.	NICU				38				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				111				
22.	Total				611	0.31%		122	4.10

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

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

PRELIMINARY

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	65,187,776	219,109,929	0.297512	328,287	139,758	97,669	41,580
2.	Recovery Room							
3.	Delivery and Labor Room	6,456,182	11,182,409	0.577352	23,049		13,307	
4.	Anesthesiology	6,258,948	31,578,391	0.198204	37,387	18,550	7,410	3,677
5.	Radiology - Diagnostic	37,998,814	205,978,276	0.184480	265,614	212,813	49,000	39,260
6.	Radiology - Therapeutic	12,455,566	44,591,831	0.279324	1,976	3,916	552	1,094
7.	Nuclear Medicine							
8.	Laboratory	38,918,145	203,172,171	0.191553	414,819	58,363	79,460	11,180
9.	Blood							
10.	Blood - Administration	8,737,341	22,799,062	0.383232	48,635		18,638	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,766,795	31,007,529	0.282731	92,579	3,766	26,175	1,065
13.	Physical Therapy	5,540,532	11,023,241	0.502623	17,030	2,126	8,560	1,069
14.	Occupational Therapy	2,235,631	4,414,079	0.506477	13,129	1,563	6,650	792
15.	Speech Pathology							
16.	EKG	787,383	4,593,159	0.171425	44,353	48,713	7,603	8,351
17.	EEG	2,508,726	8,167,883	0.307145	8,818	2,058	2,708	632
18.	Med. / Surg. Supplies	19,260,241	40,734,683	0.472822	181,064	23,267	85,611	11,001
19.	Drugs Charged to Patients	94,747,523	164,161,138	0.577162	246,435	75,789	142,233	43,743
20.	Renal Dialysis	7,302,395	21,590,614	0.338221	41,034		13,879	
21.	Ambulance							
22.	Ultrasound	3,114,328	14,705,478	0.211780				
23.	Cardiology	8,072,582	66,024,914	0.122266	56,895	71,457	6,956	8,737
24.	Orthotic Services	2,026,528	3,765,962	0.538117				
25.	Family Care Clinic	11,372,234	13,820,034	0.822880				
26.	Emer Mobile Crit Care	5,020,804	14,853,304	0.338026				
27.	Digestive Disease	5,594,896	23,725,015	0.235823	26,275	35,165	6,196	8,293
28.	Implants	55,268,507	110,827,846	0.498688	7,684	280	3,832	140
29.	ASC	16,147,292	39,020,982	0.413810				
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	11,864,222	60,835,240	0.195022	44,553	43,543	8,689	8,492
45.	Observation	1,936,422	6,420,217	0.301613	1,933	18,250	583	5,504
46.	Total				1,901,549	759,377	585,711	194,610

* 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: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	124,361,384	18,673,577		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	127,032	23,503		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	978.98	794.52		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	260			
3.	Program general inpatient routine cost (Line 1c X Line 2)	254,535			
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)	254,535			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit					
9.	Coronary Care Unit	5,667,689	3,412	1,661.10	6	9,967
10.	Surgical ICU	17,976,168	11,120	1,616.56	181	292,597
11.	Medical ICU	8,307,980	4,811	1,726.87	15	25,903
12.	Burn ICU	7,360,197	5,031	1,462.97		
13.	NICU	25,016,288	19,697	1,270.06	38	48,262
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,140,238	2,937	728.72	111	80,888
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					585,711
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,297,863

**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: 07/01/2008 To: 06/30/2009

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Medical ICU						
10.	Burn ICU						
11.	NICU						
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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	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 (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

PRELIMINARY

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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.	Family Care Clinic							
26.	Emer Mobile Crit Care							
27.	Digestive Disease							
28.	Implants							
29.	ASC							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
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

PRELIMINARY

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical ICU							
54.	Medical ICU							
55.	Burn ICU							
56.	NICU							
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**

PRELIMINARY

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		194,610
2.	Inpatient Operating Services (BHF Page 4, Line 25)	1,297,863	
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)	67,115	14,337
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,364,978	208,947
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	87.00%	13.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	1,901,549	759,377
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,327,405	
	B. Psych		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	H. Medical ICU		
	I. Burn ICU		
	J. NICU		
	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)	3,228,954	759,377
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,414,406
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: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	1,364,978	208,947
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,364,978	208,947
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	1,364,978	208,947

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

PRELIMINARY

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	2,414,406
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 07/01/2008 To: 06/30/2009

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, 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 Sub II	Sub III Sub III
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 Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

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

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: 07/01/2008 To: 06/30/2009

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	5,297,932	219,109,929	0.024179	328,287	139,758	7,938	3,379
2.	Recovery Room							
3.	Delivery and Labor Room	652,678	11,182,409	0.058366	23,049		1,345	
4.	Anesthesiology	7,458,894	31,578,391	0.236202	37,387	18,550	8,831	4,382
5.	Radiology - Diagnostic	3,940,448	205,978,276	0.019130	265,614	212,813	5,081	4,071
6.	Radiology - Therapeutic	717,873	44,591,831	0.016099	1,976	3,916	32	63
7.	Nuclear Medicine							
8.	Laboratory	940,621	203,172,171	0.004630	414,819	58,363	1,921	270
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	11,012	4,593,159	0.002397	44,353	48,713	106	117
17.	EEG	218,343	8,167,883	0.026732	8,818	2,058	236	55
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	795,273	21,590,614	0.036834	41,034		1,511	
21.	Ambulance							
22.	Ultrasound	450,194	14,705,478	0.030614				
23.	Cardiology	9,544	66,024,914	0.000145	56,895	71,457	8	10
24.	Orthotic Services							
25.	Family Care Clinic	4,015,480	13,820,034	0.290555				
26.	Emer Mobile Crit Care							
27.	Digestive Disease	61,964	23,725,015	0.002612	26,275	35,165	69	92
28.	Implants							
29.	ASC							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	2,652,416	60,835,240	0.043600	44,553	43,543	1,943	1,898
45.	Observation							
46.	Ancillary Total						29,021	14,337

* 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: 07/01/2008 To: 06/30/2009

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	8,492,463	127,032	66.85	260		17,381	
48.	Psych	1,477,594	23,503	62.87				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit	681,605	3,412	199.77	6		1,199	
53.	Surgical ICU	682,487	11,120	61.37	181		11,108	
54.	Medical ICU	519,500	4,811	107.98	15		1,620	
55.	Burn ICU	201,897	5,031	40.13				
56.	NICU	598,056	19,697	30.36	38		1,154	
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	149,037	2,937	50.74	111		5,632	
67.	Routine Total (lines 47-66)						38,094	
68.	Ancillary Total (from line 46)						29,021	14,337
69.	Total (Lines 67-68)						67,115	14,337

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	500		500
Newborn Days	111		111
Total Inpatient Revenue	3,228,954		3,228,954
Ancillary Revenue	1,901,549		1,901,549
Routine Revenue	1,327,405		1,327,405
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue	759,377		759,377
Outpatient Received and Receivable			

Notes:

- Total Surgical ICU Days were adjusted to filed S-3.
- BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
- GME Costs were adjusted to filed W/S B, Pt 1, Col 26.
- Included Recovery Room charges with Operating Room for Cost-to-Charge ratio.
- Included Nuclear Medicine charges with Radiology-Diagnostic for Cost-to-Charge ratio.
- Included IV Therapy charges with Drugs for Cost-to-Charge ratio.
- Included Speech Path. charges with Occupational Therapy for Cost-to-Charge ratio.