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:** Iowa	**Zip:** 52242-1009	
Period Covered by Statement:	**From:** 07/01/2014	**To:** 06/30/2015	

Type of Control

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

Type of Hospital

[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)

[ ]	Medicaid Hospital	[ ]	Medicaid Sub II Rehab	[ ]	DHS - Office of Rehabilitation Services
[XXXX]	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 07/01/2014 and ending 06/30/2015 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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	439	156,452		122,426	78.25%	28,903	28,903	6.11
2.	Psych	73	26,645		26,022	97.66%	1,974	1,974	13.18
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit	24	8,760		5,767	65.83%			
7.	Medical ICU	26	9,490		7,317	77.10%			
8.	Burn ICU	17	6,205		4,923	79.34%			
9.	Surgical ICU	36	13,140		9,086	69.15%			
10.	Neonatal ICU	79	28,599		22,335	78.10%			
11.	Pediatric ICU	20	7,300		4,805	65.82%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	24	8,760		3,690	42.12%			
22.	**Total**	**738**	**265,351**		**206,371**	**77.77%**	**30,877**	**30,877**	**6.56**
23.	Observation Bed Days				4,915				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				54		6	6	9.00
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Medical ICU								
8.	Burn ICU								
9.	Surgical ICU								
10.	Neonatal ICU								
11.	Pediatric ICU								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**54**	**0.03%**	**6**	**6**	**9.00**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		889,408

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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	73,126,174	348,357,693	0.209917				
2.	Recovery Room							
3.	Delivery and Labor Room	5,606,260	19,230,649	0.291527				
4.	Anesthesiology	8,802,908	54,876,485	0.160413				
5.	Radiology - Diagnostic	45,347,310	349,250,465	0.129842				
6.	Radiology - Therapeutic	10,720,611	77,977,054	0.137484				
7.	Nuclear Medicine							
8.	Laboratory	57,701,488	355,132,769	0.162479	3,401		553	
9.	Blood							
10.	Blood - Administration	7,872,741	27,776,879	0.283428				
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,035,329	53,091,313	0.170185				
13.	Physical Therapy	6,795,145	19,297,417	0.352127				
14.	Occupational Therapy	2,500,962	7,196,283	0.347535	2,715		944	
15.	Speech Pathology							
16.	EKG	890,100	6,947,147	0.128125	183		23	
17.	EEG	4,065,482	19,159,809	0.212188				
18.	Med. / Surg. Supplies	27,492,189	71,869,002	0.382532				
19.	Drugs Charged to Patients	144,792,910	426,534,904	0.339463	3,507		1,190	
20.	Renal Dialysis	9,510,208	42,446,403	0.224052				
21.	Ambulance	1,518,306	2,049,269	0.740901				
22.	Ultrasound	4,199,943	22,758,271	0.184546				
23.	Cardiology	18,266,764	120,809,645	0.151203				
24.	Orthotic Services	3,028,441	7,287,872	0.415545				
25.	Digestive Disease	6,960,065	37,817,734	0.184042				
26.	Implants	76,175,611	182,083,281	0.418356				
27.	ASC	19,252,249	73,185,822	0.263060				
28.	Other	9,370,538	29,259,194	0.320260	1,779		570	
29.	Kidney Acquisition	5,317,854	9,776,000	0.543970				
30.	Heart Acquisition	1,570,209	3,029,000	0.518392				
31.	Liver Acquisition	2,116,166	4,131,000	0.512265				
32.	Lung Acquisition	1,619,561	3,351,000	0.483307				
33.	Pancreas Acquisition	480,853	447,300	1.075012				
34.	Bone Marrow Transpl.	5,103,427	11,082,809	0.460481				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	136,645,052	189,137,469	0.722464				
44.	Emergency	14,173,579	102,885,993	0.137760	2,254		311	
45.	Observation	7,203,392	16,600,933	0.433915				
46.	**Total**				**13,839**		**3,591**	

* 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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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)	126,668,128	21,558,658		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	127,341	26,022		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	994.72	828.48		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		54		
3.	Program general inpatient routine cost (Line 1c X Line 2)		44,738		
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)		44,738		

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	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	11,588,415	5,767	2,009.44		
10.	Medical ICU	12,480,514	7,317	1,705.69		
11.	Burn ICU	7,811,578	4,923	1,586.75		
12.	Surgical ICU	15,752,741	9,086	1,733.74		
13.	Neonatal ICU	29,700,815	22,335	1,329.79		
14.	Pediatric ICU	11,076,422	4,805	2,305.19		
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,740,694	3,690	742.74		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					3,591
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**48,329**

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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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.	Medical ICU						
9.	Burn ICU						
10.	Surgical ICU						
11.	Neonatal ICU						
12.	Pediatric ICU						
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 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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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.	Pediatric ICU							
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:	Medicaid Provider Number:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	48,329	
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)	2,805	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**51,134**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	13,839	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	75,810	
	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. Pediatric ICU		
	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)**	89,649	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		38,515
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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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)	51,134	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	51,134	
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)**	**51,134**	

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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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)	38,515
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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
16-0058	**9003**
Program:	**Period Covered by Statement:**
Medicaid Psych	**From: 07/01/2014 To: 06/30/2015**

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

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(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 Psych	From: 07/01/2014 To: 06/30/2015

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	11,657,256	348,357,693	0.033463				
2.	Recovery Room							
3.	Delivery and Labor Room	643,535	19,230,649	0.033464				
4.	Anesthesiology	1,836,339	54,876,485	0.033463				
5.	Radiology - Diagnostic	11,687,102	349,250,465	0.033463				
6.	Radiology - Therapeutic	2,609,378	77,977,054	0.033463				
7.	Nuclear Medicine							
8.	Laboratory	11,883,968	355,132,769	0.033463	3,401		114	
9.	Blood							
10.	Blood - Administration	929,514	27,776,879	0.033464				
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,776,607	53,091,313	0.033463				
13.	Physical Therapy	645,744	19,297,417	0.033463				
14.	Occupational Therapy	240,803	7,196,283	0.033462	2,715		91	
15.	Speech Pathology							
16.	EKG	232,470	6,947,147	0.033463	183		6	
17.	EEG	641,160	19,159,809	0.033464				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	2,139,062	42,446,403	0.050394				
21.	Ambulance	68,567	2,049,269	0.033459				
22.	Ultrasound	761,561	22,758,271	0.033463				
23.	Cardiology	4,042,717	120,809,645	0.033464				
24.	Orthotic Services	243,881	7,287,872	0.033464				
25.	Digestive Disease	1,265,519	37,817,734	0.033464				
26.	Implants							
27.	ASC	2,449,054	73,185,822	0.033464				
28.	Other	979,106	29,259,194	0.033463	1,779		60	
29.	Kidney Acquisition							
30.	Heart Acquisition							
31.	Liver Acquisition							
32.	Lung Acquisition							
33.	Pancreas Acquisition							
34.	Bone Marrow Transpl.	370,875	11,082,809	0.033464				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	6,311,335	189,137,469	0.033369				
44.	Emergency	3,442,918	102,885,993	0.033463	2,254		75	
45.	Observation	201,249	16,600,933	0.012123				
46.	**Ancillary Total**						**346**	

* 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:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

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	9,161,048	127,341	71.94				
48.	Psych	1,184,740	26,022	45.53	54		2,459	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	869,547	5,767	150.78				
53.	Medical ICU	1,109,279	7,317	151.60				
54.	Burn ICU	476,820	4,923	96.86				
55.	Surgical ICU	1,418,448	9,086	156.11				
56.	Neonatal ICU	3,061,904	22,335	137.09				
57.	Pediatric ICU	810,484	4,805	168.68				
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	174,009	3,690	47.16				
67.	**Routine Total (lines 47-66)**						**2,459**	
68.	**Ancillary Total (from line 46)**						**346**	
69.	**Total (Lines 67-68)**						**2,805**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
16-0058	9003
Program:	**Period Covered by Statement:**
Medicaid Psych	From: 07/01/2014 To: 06/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	54		54
Newborn Days			
Total Inpatient Revenue	89,649		89,649
Ancillary Revenue	13,839		13,839
Routine Revenue	75,810		75,810
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Lab includes Lab and Anatomical Lab
Cardiolgy includes Cardiology and Cardiac Cath
Other includes lines 76.00, 76.02, 76.03, 76.04, 76.07 76.98, and 76.99
Recreational Therapy, Diabetes Education, Cardiac Rehab and Home Program Dialysis have not been filed on BHF Page 3
GME costs were adjusted to as filed W/S B Part 1, column 25