

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: 07/01/2015	To: 06/30/2016

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<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 & (9003 for the cost report beginning 07/01/2015 and ending 06/30/2016 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

Preliminary

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Inpatient Statistics	Total Beds Available (1)	Total Bed Days Available (2)	Total Private Room Days (3)	Total Inpatient Days Including Private Room Days (4)	Percent Of Occupancy (Column 4 Divided By Column 2) (5)	Number Of Admissions Excluding Newborn (6)	Number Of Discharges Including Deaths Excluding Newborn (7)	Average Length Of Stay By Program Excluding Newborn (8)
Part I-Hospital									
1.	Adults and Pediatrics	428	156,477		131,342	83.94%		31,652	5.62
2.	Psych	73	26,718		26,193	98.04%		1,704	15.37
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit	24	8,784		6,780	77.19%			
7.	Medical ICU	26	9,516		7,779	81.75%			
8.	Burn ICU	17	6,222		5,139	82.59%			
9.	Surgical ICU	36	13,176		10,419	79.08%			
10.	Neonatal ICU	76	27,816		11,367	40.86%			
11.	Pediatric ICU	20	7,320		4,905	67.01%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				17,062				
22.	Total	700	256,029		220,986	86.31%		33,356	6.11
23.	Observation Bed Days				5,099				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				11			2	5.50
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				11	0.00%		2	5.50

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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	96,853,018	473,364,652	0.204606				
2.	Recovery Room							
3.	Delivery and Labor Room	6,267,517	23,206,695	0.270074				
4.	Anesthesiology	9,566,282	60,315,315	0.158605				
5.	Radiology - Diagnostic	30,937,011	119,523,013	0.258837				
6.	Radiology - Therapeutic	12,910,555	81,240,029	0.158919				
7.	Nuclear Medicine							
8.	Laboratory	60,120,128	396,970,347	0.151447	1,687		255	
9.	Blood							
10.	Blood - Administration	9,573,308	32,987,578	0.290209				
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,881,805	66,581,608	0.148416				
13.	Physical Therapy	8,031,725	23,193,254	0.346296				
14.	Occupational Therapy	2,742,924	8,659,608	0.316749				
15.	Speech Pathology							
16.	EKG	939,965	8,589,266	0.109435				
17.	EEG	4,623,397	23,346,016	0.198038				
18.	Med. / Surg. Supplies	34,192,746	85,659,330	0.399171				
19.	Drugs Charged to Patients	171,232,241	537,269,345	0.318708	195		62	
20.	Renal Dialysis	10,284,532	44,920,082	0.228952				
21.	Ambulance	1,505,541	1,606,032	0.937429				
22.	Ultrasound	4,733,296	30,681,074	0.154274				
23.	Cardiology	19,597,016	145,354,499	0.134822				
24.	Orthotic Services	3,311,497	7,247,848	0.456894				
25.	Digestive Disease	7,751,752	41,412,521	0.187184				
26.	Implants	79,416,692	183,909,298	0.431825				
27.	ASC							
28.	Other	9,494,730	31,779,205	0.298772				
29.	Kidney Acquisition	5,590,610	10,000,000	0.559061				
30.	Heart Acquisition	1,758,590	3,262,000	0.539114				
31.	Liver Acquisition	2,046,985	2,754,000	0.743277				
32.	Lung Acquisition	1,259,851	1,848,000	0.681738				
33.	Pancreas Acquisition	326,707	337,200	0.968882				
34.	Bone Marrow Transpl.	4,864,144	10,549,272	0.461088				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	143,334,776	231,269,287	0.619774				
44.	Emergency	15,822,223	114,339,638	0.138379	4,666		646	
45.	Observation	7,617,527	23,843,539	0.319480				
46.	Total				6,548		963	

* 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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	141,430,064	22,220,890		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	136,441	26,193		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,036.57	848.35		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		11		
3.	Program general inpatient routine cost (Line 1c X Line 2)		9,332		
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)		9,332		

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit					
9.	Coronary Care Unit	13,696,591	6,780	2,020.15		
10.	Medical ICU	14,418,480	7,779	1,853.51		
11.	Burn ICU	8,802,996	5,139	1,712.98		
12.	Surgical ICU	17,921,278	10,419	1,720.06		
13.	Neonatal ICU	21,832,101	11,367	1,920.66		
14.	Pediatric ICU	12,214,831	4,905	2,490.28		
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	14,716,837	17,062	862.55		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					963
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					10,295

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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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.	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 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)	
						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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	10,295	
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)	687	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	10,982	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	6,548	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	16,208	
	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)	22,756	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		11,774
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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	10,982	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	10,982	
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)	10,982	

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.

Preliminary

Medicare Provider Number: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	11,774
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)		
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)
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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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: 16-0058	Medicaid Provider Number: 9003
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	14,604,846	473,364,652	0.030853				
2.	Recovery Room							
3.	Delivery and Labor Room	696,475	23,206,695	0.030012				
4.	Anesthesiology	1,860,238	60,315,315	0.030842				
5.	Radiology - Diagnostic	3,686,333	119,523,013	0.030842				
6.	Radiology - Therapeutic	2,505,607	81,240,029	0.030842				
7.	Nuclear Medicine							
8.	Laboratory	12,343,396	396,970,347	0.031094	1,687		52	
9.	Blood							
10.	Blood - Administration	1,017,664	32,987,578	0.030850				
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,053,525	66,581,608	0.030842				
13.	Physical Therapy	715,320	23,193,254	0.030842				
14.	Occupational Therapy	267,092	8,659,608	0.030843				
15.	Speech Pathology							
16.	EKG	264,902	8,589,266	0.030841				
17.	EEG	720,038	23,346,016	0.030842				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,886,599	44,920,082	0.041999				
21.	Ambulance	49,532	1,606,032	0.030841				
22.	Ultrasound	946,265	30,681,074	0.030842				
23.	Cardiology	4,482,952	145,354,499	0.030842				
24.	Orthotic Services	223,544	7,247,848	0.030843				
25.	Digestive Disease	1,277,231	41,412,521	0.030842				
26.	Implants							
27.	ASC							
28.	Other	980,099	31,779,205	0.030841				
29.	Kidney Acquisition							
30.	Heart Acquisition							
31.	Liver Acquisition							
32.	Lung Acquisition							
33.	Pancreas Acquisition							
34.	Bone Marrow Transpl.	325,353	10,549,272	0.030841				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	7,143,170	231,269,287	0.030887				
44.	Emergency	3,520,126	114,339,638	0.030787	4,666		144	
45.	Observation	53,357	23,843,539	0.002238				
46.	Ancillary Total						196	

* 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 Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	9,104,694	136,441	66.73				
48.	Psych	1,169,654	26,193	44.66	11		491	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	976,767	6,780	144.07				
53.	Medical ICU	1,081,384	7,779	139.01				
54.	Burn ICU	463,895	5,139	90.27				
55.	Surgical ICU	1,532,727	10,419	147.11				
56.	Neonatal ICU	1,708,187	11,367	150.28				
57.	Pediatric ICU	784,405	4,905	159.92				
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	1,891,080	17,062	110.84				
67.	Routine Total (lines 47-66)						491	
68.	Ancillary Total (from line 46)						196	
69.	Total (Lines 67-68)						687	

