

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: 07/01/2014	To: 06/30/2015	

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 07/01/2014 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)

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: 07/01/2014 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				337		91	91	7.93
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Medical ICU				5				
8.	Burn ICU				11				
9.	Surgical ICU				42				
10.	Neonatal ICU				306				
11.	Pediatric ICU				21				
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1				
22.	Total				723	0.35%	91	91	7.93

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	201	867,577

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:	07/01/2014	To:	06/30/2015

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	73,126,174	348,357,693	0.209917	585,630	232,808	122,934	48,870
2.	Recovery Room							
3.	Delivery and Labor Room	5,606,260	19,230,649	0.291527	23,475		6,844	
4.	Anesthesiology	8,802,908	54,876,485	0.160413	61,335	4,207	9,839	675
5.	Radiology - Diagnostic	45,347,310	349,250,465	0.129842	387,581	211,166	50,324	27,418
6.	Radiology - Therapeutic	10,720,611	77,977,054	0.137484	6,442	13,340	886	1,834
7.	Nuclear Medicine							
8.	Laboratory	57,701,488	355,132,769	0.162479				
9.	Blood							
10.	Blood - Administration	7,872,741	27,776,879	0.283428	635,970	99,484	180,252	28,197
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,035,329	53,091,313	0.170185	382,588	10,697	65,111	1,820
13.	Physical Therapy	6,795,145	19,297,417	0.352127	29,048	395	10,229	139
14.	Occupational Therapy	2,500,962	7,196,283	0.347535	21,453	1,477	7,456	513
15.	Speech Pathology							
16.	EKG	890,100	6,947,147	0.128125	73,726	63,468	9,446	8,132
17.	EEG	4,065,482	19,159,809	0.212188	22,268	6,463	4,725	1,371
18.	Med. / Surg. Supplies	27,492,189	71,869,002	0.382532	368,717	5,380	141,046	2,058
19.	Drugs Charged to Patients	144,792,910	426,534,904	0.339463	436,153	105,037	148,058	35,656
20.	Renal Dialysis	9,510,208	42,446,403	0.224052	6,096		1,366	
21.	Ambulance	1,518,306	2,049,269	0.740901	6,154		4,560	
22.	Ultrasound	4,199,943	22,758,271	0.184546				
23.	Cardiology	18,266,764	120,809,645	0.151203	18,006	29,005	2,723	4,386
24.	Orthotic Services	3,028,441	7,287,872	0.415545				
25.	Digestive Disease	6,960,065	37,817,734	0.184042	12,179	23,136	2,241	4,258
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	9,400		3,010	
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		9,049		6,538
44.	Emergency	14,173,579	102,885,993	0.137760	109,517	91,350	15,087	12,584
45.	Observation	7,203,392	16,600,933	0.433915	15,977	17,423	6,933	7,560
46.	Total				3,211,715	923,885	793,070	192,009

* 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: 07/01/2014 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)	337			
3.	Program general inpatient routine cost (Line 1c X Line 2)	335,221			
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)	335,221			

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	11,588,415	5,767	2,009.44		
10.	Medical ICU	12,480,514	7,317	1,705.69	5	8,528
11.	Burn ICU	7,811,578	4,923	1,586.75	11	17,454
12.	Surgical ICU	15,752,741	9,086	1,733.74	42	72,817
13.	Neonatal ICU	29,700,815	22,335	1,329.79	306	406,916
14.	Pediatric ICU	11,076,422	4,805	2,305.19	21	48,409
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	1	743
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					793,070
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,683,158

**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: 07/01/2014 To: 06/30/2015

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)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

Preliminary

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2014 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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	16-0058	Medicaid Provider Number:	9003
Program:	Medicaid Hospital	Period Covered by Statement:	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**

BHF Page 7

Preliminary

Medicare Provider Number: 16-0058		Medicaid Provider Number: 9003	
Program: Medicaid Hospital		Period Covered by Statement: 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)		192,009
2.	Inpatient Operating Services (BHF Page 4, Line 25)	1,683,158	
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)	158,469	26,847
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,841,627	218,856
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	89.00%	11.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	3,211,715	923,885
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,458,355	
	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. 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)	5,670,070	923,885
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		4,533,472
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: 07/01/2014 To: 06/30/2015

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)	1,841,627	218,856
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,841,627	218,856
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)	1,841,627	218,856

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: 07/01/2014 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)	4,533,472
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: 07/01/2014 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

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:	07/01/2014	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	585,630	232,808	19,597	7,790
2.	Recovery Room							
3.	Delivery and Labor Room	643,535	19,230,649	0.033464	23,475		786	
4.	Anesthesiology	1,836,339	54,876,485	0.033463	61,335	4,207	2,052	141
5.	Radiology - Diagnostic	11,687,102	349,250,465	0.033463	387,581	211,166	12,970	7,066
6.	Radiology - Therapeutic	2,609,378	77,977,054	0.033463	6,442	13,340	216	446
7.	Nuclear Medicine							
8.	Laboratory	11,883,968	355,132,769	0.033463				
9.	Blood							
10.	Blood - Administration	929,514	27,776,879	0.033464	635,970	99,484	21,282	3,329
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,776,607	53,091,313	0.033463	382,588	10,697	12,803	358
13.	Physical Therapy	645,744	19,297,417	0.033463	29,048	395	972	13
14.	Occupational Therapy	240,803	7,196,283	0.033462	21,453	1,477	718	49
15.	Speech Pathology							
16.	EKG	232,470	6,947,147	0.033463	73,726	63,468	2,467	2,124
17.	EEG	641,160	19,159,809	0.033464	22,268	6,463	745	216
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	2,139,062	42,446,403	0.050394	6,096		307	
21.	Ambulance	68,567	2,049,269	0.033459	6,154		206	
22.	Ultrasound	761,561	22,758,271	0.033463				
23.	Cardiology	4,042,717	120,809,645	0.033464	18,006	29,005	603	971
24.	Orthotic Services	243,881	7,287,872	0.033464				
25.	Digestive Disease	1,265,519	37,817,734	0.033464	12,179	23,136	408	774
26.	Implants							
27.	ASC	2,449,054	73,185,822	0.033464				
28.	Other	979,106	29,259,194	0.033463	9,400		315	
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		9,049		302
44.	Emergency	3,442,918	102,885,993	0.033463	109,517	91,350	3,665	3,057
45.	Observation	201,249	16,600,933	0.012123	15,977	17,423	194	211
46.	Ancillary Total						80,306	26,847

* 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: 07/01/2014 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	337		24,244	
48.	Psych	1,184,740	26,022	45.53				
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	5		758	
54.	Burn ICU	476,820	4,923	96.86	11		1,065	
55.	Surgical ICU	1,418,448	9,086	156.11	42		6,557	
56.	Neonatal ICU	3,061,904	22,335	137.09	306		41,950	
57.	Pediatric ICU	810,484	4,805	168.68	21		3,542	
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	174,009	3,690	47.16	1		47	
67.	Routine Total (lines 47-66)						78,163	
68.	Ancillary Total (from line 46)						80,306	26,847
69.	Total (Lines 67-68)						158,469	26,847

Preliminary

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	722		722
Newborn Days	1		1
Total Inpatient Revenue	5,670,070		5,670,070
Ancillary Revenue	3,211,715		3,211,715
Routine Revenue	2,458,355		2,458,355
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	201		201
Total Outpatient Revenue	923,885		923,885
Outpatient Received and Receivable			

Notes:

[illegible]