

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: Clarian Health Partners, Inc.		Medicare Provider Number: 15-0056	
Street: I-65 at 21st Street		Medicaid Provider Number: 9024	
City: Indianapolis		State: Indiana	
		Zip: 46202	
Period Covered by Statement:		From: 01/01/2010	To: 12/31/2010

Type of Control

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

Type of Hospital

☐ XXXX General Short-Term XXXX	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify) _____

Health Care Program

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

☐ XXXX Medicaid Hospital XXXX	☐ Medicaid Sub II	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I	☐ Medicaid Sub III	☐ 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)) Clarian Health Partners, Inc. 9024 for the cost report beginning 01/01/2010 and ending 12/31/2010 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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	1,229	448,585		265,954	59.29%		57,317	5.83
2.	Behavioral Care Center	45	16,425		6,845	41.67%		934	7.33
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	57	20,805		20,560	98.82%			
6.	Coronary Care Unit	52	18,980		13,859	73.02%			
7.	Neonatal ICU	35	12,775		8,352	65.38%			
8.	Burn ICU	7	2,555		1,652	64.66%			
9.	UH Surg 6IC	18	6,570		5,748	87.49%			
10.	UH NS 3IC	9	3,285		2,339	71.20%			
11.	RH Ped IC	34	12,410		9,422	75.92%			
12.	Transplant ICU	12	4,380		4,196	95.80%			
13.	Pediatric Cancer Center	8	2,920		2,206	75.55%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				12,439				
22.	Total	1,506	549,690		353,572	64.32%		58,251	5.86
23.	Observation Bed Days				10,726				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,836			179	12.42
2.	Behavioral Care Center								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				31				
6.	Coronary Care Unit				55				
7.	Neonatal ICU								
8.	Burn ICU				40				
9.	UH Surg 6IC								
10.	UH NS 3IC				5				
11.	RH Ped IC				180				
12.	Transplant ICU				1				
13.	Pediatric Cancer Center				76				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				2,224	0.63%		179	12.42

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
15-0056		9024	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2010	To: 12/31/2010

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	140,294,579	552,594,042	0.253884	2,196,539		557,666	
2.	Recovery Room	11,248,508	55,085,300	0.204202	121,885		24,889	
3.	Delivery and Labor Room							
4.	Anesthesiology	8,444,125	31,969,707	0.264129	85,858		22,678	
5.	Radiology - Diagnostic	84,853,101	475,252,580	0.178543	891,993		159,259	
6.	Radiology - Therapeutic	14,784,079	76,381,208	0.193556	25,832		5,000	
7.	Nuclear Medicine	6,717,482	19,238,416	0.349170	24,016		8,386	
8.	Laboratory	73,986,028	618,434,908	0.119634	2,001,570		239,456	
9.	Blood							
10.	Blood - Administration	17,190,206	62,410,299	0.275439	540,550		148,889	
11.	Intravenous Therapy							
12.	Respiratory Therapy	36,030,987	116,248,163	0.309949	504,890		156,490	
13.	Physical Therapy	12,498,114	39,768,673	0.314270	100,110		31,462	
14.	Occupational Therapy	3,870,315	9,769,404	0.396167	45,268		17,934	
15.	Speech Pathology	7,572,926	10,245,464	0.739149	15,770		11,656	
16.	EKG	5,715,550	53,106,744	0.107624	67,922		7,310	
17.	EEG	5,941,053	23,782,345	0.249809	6,201		1,549	
18.	Med. / Surg. Supplies	52,530,810	81,897,443	0.641422	7,396		4,744	
19.	Drugs Charged to Patients	108,429,336	564,114,827	0.192211	3,416,728		656,733	
20.	Renal Dialysis	17,027,291	30,820,050	0.552474	42,943		23,725	
21.	Ambulance	24,505,505	34,855,884	0.703052				
22.	Endoscopy Unit	3,053,471	13,145,499	0.232283				
23.	Pulmonary Function	5,561,113	23,375,012	0.237908	43,121		10,259	
24.	Transplant Immunology	4,377,813	21,726,867	0.201493	16,667		3,358	
25.	Bone Marrow Trans Lab	3,288,416	11,218,398	0.293127	48,028		14,078	
26.	OP Retail Pharm	53,011,590	44,764,095	1.184244				
27.	RH NBN ECMO IC	651,039	1,297,643	0.501709				
28.	Cardiology	15,470,080	66,919,677	0.231174	246,500		56,984	
29.	Psych Other Ancillary	2,203,943	979,534	2.249991				
30.	Cardiac Catheterization	14,848,653	61,179,974	0.242704	69,117		16,775	
31.	Day Surgery	7,972,824	8,326,735	0.957497	15,155		14,511	
32.	Oncology	7,513,458	2,594	#####				
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Par	29,764,020	64,134,820	0.464085	345,193		160,199	
34.	Implantable Devices	62,244,179	261,452,604	0.238071				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	60,848,595	72,408,868	0.840347	29,668		24,931	
44.	Emergency	42,081,145	246,714,552	0.170566	217,659		37,125	
45.	Observation	10,879,918	16,784,757	0.648202				
46.	Total				11,126,579		2,416,046	

* 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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Behavioral Care C	Sub II	Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	280,650,651	7,877,082		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	276,680	6,845		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,014.35	1,150.78		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,836			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,862,347			
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)	1,862,347			

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	29,372,456	20,560	1,428.62	31	44,287
9.	Coronary Care Unit	22,465,790	13,859	1,621.03	55	89,157
10.	Neonatal ICU	7,789,592	8,352	932.66		
11.	Burn ICU	2,544,427	1,652	1,540.21	40	61,608
12.	UH Surg 6IC	9,136,427	5,748	1,589.50		
13.	UH NS 3IC	3,454,507	2,339	1,476.92	5	7,385
14.	RH Ped IC	15,923,237	9,422	1,690.01	180	304,202
15.	Transplant ICU	5,751,741	4,196	1,370.77	1	1,371
16.	Pediatric Cancer Center	2,594,700	2,206	1,176.20	76	89,391
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	7,655,301	12,439	615.43		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,416,046
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,875,794

Hospital Statement of Cost**Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**

PRELIMINARY

Medicare Provider Number:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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.	Behavioral Care Center						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
9.	Burn ICU						
10.	UH Surg 6IC						
11.	UH NS 3IC						
12.	RH Ped IC						
13.	Transplant ICU						
14.	Pediatric Cancer Center						
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)	
		(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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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	1,153,882	552,594,042	0.002088	2,196,539		4,586	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,802,211	31,969,707	0.212771	85,858		18,268	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,897,878	618,434,908	0.004686	2,001,570		9,379	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	776,082	53,106,744	0.014614	67,922		993	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	164,923	30,820,050	0.005351	42,943		230	
21.	Ambulance							
22.	Endoscopy Unit							
23.	Pulmonary Function							
24.	Transplant Immunology							
25.	Bone Marrow Trans Lab							
26.	OP Retail Pharm							
27.	RH NBN ECMO IC							
28.	Cardiology							
29.	Psych Other Ancillary							
30.	Cardiac Catheterization	1,725,414	61,179,974	0.028202	69,117		1,949	
31.	Day Surgery							
32.	Oncology							
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Pand							
34.	Implantable Devices							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	3,358,403	72,408,868	0.046381	29,668		1,376	
44.	Emergency							
45.	Observation							
46.	Ancillary Total						36,781	

* 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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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	2,801,735	276,680	10.13	1,836		18,599	
48.	Behavioral Care Center	82,573	6,845	12.06				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU	30,942	8,352	3.70				
54.	Burn ICU	8,750	1,652	5.30	40		212	
55.	UH Surg 6IC							
56.	UH NS 3IC							
57.	RH Ped IC	748,575	9,422	79.45	180		14,301	
58.	Transplant ICU							
59.	Pediatric Cancer Center	35,000	2,206	15.87	76		1,206	
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						34,318	
68.	Ancillary Total (from line 46)						36,781	
69.	Total (Lines 67-68)						71,099	

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

BHF Page 7

PRELIMINARY

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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)		4,875,794	
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)		71,099	
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)		181,974	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		5,128,867	
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)		11,126,579	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		4,616,831	
B. Behavioral Care Center			
C. Sub II			
D. Sub III			
E. Intensive Care Unit		95,235	
F. Coronary Care Unit		167,567	
G. Neonatal ICU			
H. Burn ICU		136,575	
I. UH Surg 6IC			
J. UH NS 3IC		13,341	
K. RH Ped IC		664,804	
L. Transplant ICU		3,069	
M. Pediatric Cancer Center		277,254	
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)		17,101,255	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			11,972,388
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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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)	5,128,867	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,128,867	
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)	5,128,867	

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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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)	11,972,388
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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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 Behavioral Care	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 Behavioral Care	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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Behavioral Care	Sub II Sub II	Sub III Sub III
(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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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	5,002,771	552,594,042	0.009053	2,196,539		19,885	
2.	Recovery Room	3,956,149	55,085,300	0.071819	121,885		8,754	
3.	Delivery and Labor Room							
4.	Anesthesiology	737,485	31,969,707	0.023068	85,858		1,981	
5.	Radiology - Diagnostic	3,560,131	475,252,580	0.007491	891,993		6,682	
6.	Radiology - Therapeutic	50,513	76,381,208	0.000661	25,832		17	
7.	Nuclear Medicine	307,117	19,238,416	0.015964	24,016		383	
8.	Laboratory	2,883,261	618,434,908	0.004662	2,001,570		9,331	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	44,451	116,248,163	0.000382	504,890		193	
13.	Physical Therapy	642,521	39,768,673	0.016156	100,110		1,617	
14.	Occupational Therapy	119,210	9,769,404	0.012202	45,268		552	
15.	Speech Pathology							
16.	EKG	101,025	53,106,744	0.001902	67,922		129	
17.	EEG	436,429	23,782,345	0.018351	6,201		114	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	117,190	564,114,827	0.000208	3,416,728		711	
20.	Renal Dialysis	1,487,092	30,820,050	0.048251	42,943		2,072	
21.	Ambulance							
22.	Endoscopy Unit	216,194	13,145,499	0.016446				
23.	Pulmonary Function	602,110	23,375,012	0.025759	43,121		1,111	
24.	Transplant Immunology							
25.	Bone Marrow Trans Lab							
26.	OP Retail Pharm							
27.	RH NBN ECMO IC							
28.	Cardiology	986,007	66,919,677	0.014734	246,500		3,632	
29.	Psych Other Ancillary							
30.	Cardiac Catheterization	1,812,393	61,179,974	0.029624	69,117		2,048	
31.	Day Surgery							
32.	Oncology	347,526	2,594	133.973015				
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Pa	204,071	64,134,820	0.003182	345,193		1,098	
34.	Implantable Devices							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	8,639,680	72,408,868	0.119318	29,668		3,540	
44.	Emergency	2,271,047	246,714,552	0.009205	217,659		2,004	
45.	Observation							
46.	Ancillary Total						65,854	

* 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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

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	15,062,865	276,680	54.44	1,836		99,952	
48.	Behavioral Care Center	369,752	6,845	54.02				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,634,588	20,560	79.50	31		2,465	
52.	Coronary Care Unit							
53.	Neonatal ICU	323,281	8,352	38.71				
54.	Burn ICU							
55.	UH Surg 6IC							
56.	UH NS 3IC							
57.	RH Ped IC	717,280	9,422	76.13	180		13,703	
58.	Transplant ICU							
59.	Pediatric Cancer Center							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						116,120	
68.	Ancillary Total (from line 46)						65,854	
69.	Total (Lines 67-68)						181,974	

PRELIMINARY

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,224		2,224
Newborn Days			
Total Inpatient Revenue	17,101,255		17,101,255
Ancillary Revenue	11,126,579		11,126,579
Routine Revenue	5,974,676		5,974,676
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Pg 3 Costs/Charges match with the filed W/S C with exceptions for Radiology-Diagnostic and Lab costs.

Reclassified Blood charges as Blood Administration. Blood is noncovered for IL Medicaid.

Acquisition charges are from the various pages on W/S D-6, Line 51.

Clinic costs and charges include all cost centers from Lines 60.01-60.25.

This facility became Indiana University Health as of 01/01/2011.