

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: Indiana University Health		Medicare Provider Number: 15-0056	
Street: 340 W. 10th Street		Medicaid Provider Number: 9024	
City: Indianapolis	State: Indiana	Zip: 46204	
Period Covered by Statement:	From: 01/01/2011	To: 12/31/2011	

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 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)) Indiana University Health 9024 for the cost report beginning 01/01/2011 and ending 12/31/2011 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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	1,155	421,575		274,942	65.22%		58,206	5.93
2.	Psych	40	14,600		6,972	47.75%		864	8.07
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	80	29,200		22,417	76.77%			
6.	Coronary Care Unit	52	18,980		15,888	83.71%			
7.	Neonatal ICU	47	17,155		8,879	51.76%			
8.	Burn ICU	7	2,555		1,424	55.73%			
9.	UH Surg6IC	18	6,570		5,710	86.91%			
10.	UH NS 3IC	9	3,285		1,001	30.47%			
11.	RH Ped IC	35	12,775		8,854	69.31%			
12.	Transplant ICU	10	3,650		3,542	97.04%			
13.	Surgical ICU	9	3,285		2,417	73.58%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				11,928				
22.	Total	1,462	533,630		363,974	68.21%		59,070	5.96
23.	Observation Bed Days				11,456				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,032			139	8.65
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				10				
6.	Coronary Care Unit				5				
7.	Neonatal ICU								
8.	Burn ICU				28				
9.	UH Surg6IC				14				
10.	UH NS 3IC				1				
11.	RH Ped IC				69				
12.	Transplant ICU				10				
13.	Surgical ICU				34				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				1,203	0.33%		139	8.65

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: 01/01/2011	To: 12/31/2011

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	159,656,520	609,207,878	0.262072	1,412,577		370,197	
2.	Recovery Room	11,666,471	55,452,878	0.210385	90,161		18,969	
3.	Delivery and Labor Room							
4.	Anesthesiology	6,290,280	34,780,168	0.180858	72,608		13,132	
5.	Radiology - Diagnostic	81,191,830	502,819,631	0.161473	506,768		81,829	
6.	Radiology - Therapeutic	10,250,684	78,265,191	0.130974				
7.	Nuclear Medicine	8,972,418	22,212,419	0.403937	15,305		6,182	
8.	Laboratory	53,690,340	715,046,727	0.075086	1,137,789		85,432	
9.	Blood							
10.	Blood - Administration	25,124,564	72,312,420	0.347445	212,117		73,699	
11.	Intravenous Therapy							
12.	Respiratory Therapy	43,885,731	124,111,947	0.353598	397,319		140,491	
13.	Physical Therapy	14,960,039	51,584,655	0.290009	62,951		18,256	
14.	Occupational Therapy	5,303,416	11,531,185	0.459919	23,736		10,917	
15.	Speech Pathology	8,732,742	12,876,271	0.678204	11,089		7,521	
16.	EKG	5,210,682	58,771,452	0.088660	6,525		579	
17.	EEG	7,691,232	30,352,938	0.253393	41,415		10,494	
18.	Med. / Surg. Supplies	52,554,435	90,061,402	0.583540	669		390	
19.	Drugs Charged to Patients	120,517,427	650,706,550	0.185210	1,225,213		226,922	
20.	Renal Dialysis	15,216,628	36,419,956	0.417810	35,548		14,852	
21.	Ambulance	24,975,536	41,384,145	0.603505				
22.	Endoscopy	2,499,980	20,874,396	0.119763				
23.	Pulmonary Function	5,552,674	25,083,021	0.221372	37,359		8,270	
24.	Transplant Immunology	3,724,344	23,026,325	0.161743	31,565		5,105	
25.	BMT Lab	2,460,547	11,176,072	0.220162	27,905		6,144	
26.	Implantable Devices	58,489,180	282,652,908	0.206929				
27.	OP Retail Pharmacy	58,880,372	57,104,365	1.031101				
28.	RN NBN ECMO	1,175,999	2,419,974	0.485955				
29.	Cardiology	15,142,170	72,881,761	0.207764	77,325		16,065	
30.	Psych Other Ancillary	575,219	1,280,620	0.449172				
31.	Cardiac Cath	16,663,188	76,819,887	0.216912				
32.	Day Surgery	15,252,579	8,805,438	1.732177	2,483		4,301	
33.	Oncology	746,527	864	864.035880				
34.	Cardiac Rehab	1,009,458	1,005,592	1.003845				
35.	Acquisition	28,607,804	63,593,914	0.449851	419,543		188,732	
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.								
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	97,228,094	106,018,339	0.917088	10,888		9,985	
44.	Emergency	42,850,423	270,653,411	0.158322	195,068		30,884	
45.	Observation	11,958,002	19,100,513	0.626057				
46.	Total				6,053,926		1,349,348	

* 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: 01/01/2011 To: 12/31/2011

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)	298,946,759	7,206,755		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	286,398	6,972		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,043.82	1,033.67		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,032			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,077,222			
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)	1,077,222			

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	30,704,804	22,417	1,369.71	10	13,697
9.	Coronary Care Unit	22,336,182	15,888	1,405.85	5	7,029
10.	Neonatal ICU	8,278,656	8,879	932.39		
11.	Burn ICU	2,377,977	1,424	1,669.93	28	46,758
12.	UH Surg6IC	8,188,491	5,710	1,434.06	14	20,077
13.	UH NS 3IC	2,028,001	1,001	2,025.98	1	2,026
14.	RH Ped IC	15,629,042	8,854	1,765.20	69	121,799
15.	Transplant ICU	4,752,949	3,542	1,341.88	10	13,419
16.	Surgical ICU	3,786,473	2,417	1,566.60	34	53,264
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	7,935,883	11,928	665.32		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,349,348
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,704,639

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: 01/01/2011 To: 12/31/2011

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.	Neonatal ICU						
9.	Burn ICU						
10.	UH Surg6IC						
11.	UH NS 3IC						
12.	RH Ped IC						
13.	Transplant ICU						
14.	Surgical ICU						
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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	1,294,010	609,207,878	0.002124	1,412,577		3,000	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,934,710	34,780,168	0.199387	72,608		14,477	
5.	Radiology - Diagnostic	150,000	502,819,631	0.000298	506,768		151	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	3,512,502	715,046,727	0.004912	1,137,789		5,589	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	833,557	58,771,452	0.014183	6,525		93	
17.	EEG	75,804	30,352,938	0.002497	41,415		103	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	191,040	36,419,956	0.005245	35,548		186	
21.	Ambulance							
22.	Endoscopy							
23.	Pulmonary Function							
24.	Transplant Immunology							
25.	BMT Lab							
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RN NBN ECMO							
29.	Cardiology							
30.	Psych Other Ancillary	1,500,000	1,280,620	1.171308				
31.	Cardiac Cath	1,428,382	76,819,887	0.018594				
32.	Day Surgery							
33.	Oncology							
34.	Cardiac Rehab							
35.	Acquisition	1,665,036	63,593,914	0.026182	419,543		10,984	
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.								
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	4,232,551	106,018,339	0.039923	10,888		435	
44.	Emergency	4,828,474	270,653,411	0.017840	195,068		3,480	
45.	Observation							
46.	Ancillary Total						38,498	

* 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: 01/01/2011 To: 12/31/2011

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	2,895,120	286,398	10.11	1,032		10,434	
48.	Psych	1,037,580	6,972	148.82				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU	31,705	8,879	3.57				
54.	Burn ICU	8,750	1,424	6.14	28		172	
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	233,183	8,854	26.34	69		1,817	
58.	Transplant ICU							
59.	Surgical ICU	35,000	2,417	14.48	34		492	
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	23,688	11,928	1.99				
67.	Routine Total (lines 47-66)						12,915	
68.	Ancillary Total (from line 46)						38,498	
69.	Total (Lines 67-68)						51,413	

**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: 01/01/2011 To: 12/31/2011

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)		2,704,639	
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)		51,413	
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)		103,858	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		2,859,910	
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)		6,053,926	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		2,734,562	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		27,672	
F. Coronary Care Unit		15,803	
G. Neonatal ICU			
H. Burn ICU		97,439	
I. UH Surg6IC		43,971	
J. UH NS 3IC		2,307	
K. RH Ped IC		280,664	
L. Transplant ICU		31,605	
M. Surgical ICU		91,847	
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)		9,379,796	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			6,519,886
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: 01/01/2011 To: 12/31/2011

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)	2,859,910	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,859,910	
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)	2,859,910	

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: 01/01/2011 To: 12/31/2011

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)	6,519,886
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: 01/01/2011 To: 12/31/2011

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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2011 To: 12/31/2011

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	5,309,152	609,207,878	0.008715	1,412,577		12,311	
2.	Recovery Room	14,765	55,452,878	0.000266	90,161		24	
3.	Delivery and Labor Room							
4.	Anesthesiology	5,617,229	34,780,168	0.161507	72,608		11,727	
5.	Radiology - Diagnostic	5,816,052	502,819,631	0.011567	506,768		5,862	
6.	Radiology - Therapeutic	178,153	78,265,191	0.002276				
7.	Nuclear Medicine							
8.	Laboratory	2,179,174	715,046,727	0.003048	1,137,789		3,468	
9.	Blood							
10.	Blood - Administration	265,753	72,312,420	0.003675	212,117		780	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	65,946	51,584,655	0.001278	62,951		80	
14.	Occupational Therapy							
15.	Speech Pathology	668,319	12,876,271	0.051903	11,089		576	
16.	EKG	463,591	58,771,452	0.007888	6,525		51	
17.	EEG	369,101	30,352,938	0.012160	41,415		504	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	251,973	36,419,956	0.006919	35,548		246	
21.	Ambulance							
22.	Endoscopy	298,234	20,874,396	0.014287				
23.	Pulmonary Function	353,353	25,083,021	0.014087	37,359		526	
24.	Transplant Immunology	41,340	23,026,325	0.001795	31,565		57	
25.	BMT Lab	97,443	11,176,072	0.008719	27,905		243	
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RN NBN ECMO							
29.	Cardiology	403,551	72,881,761	0.005537	77,325		428	
30.	Psych Other Ancillary							
31.	Cardiac Cath	93,506	76,819,887	0.001217				
32.	Day Surgery	37,403	8,805,438	0.004248	2,483		11	
33.	Oncology	803,164	864	929.587963				
34.	Cardiac Rehab	58,071	1,005,592	0.057748				
35.	Acquisition	28,543	63,593,914	0.000449	419,543		188	
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.								
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	9,594,665	106,018,339	0.090500	10,888		985	
44.	Emergency	5,327,854	270,653,411	0.019685	195,068		3,840	
45.	Observation							
46.	Ancillary Total						41,907	

* 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: 01/01/2011 To: 12/31/2011

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	16,311,323	286,398	56.95	1,032		58,772	
48.	Psych	187,011	6,972	26.82				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,461,641	22,417	65.20	10		652	
52.	Coronary Care Unit	632,886	15,888	39.83	5		199	
53.	Neonatal ICU	1,328,764	8,879	149.65				
54.	Burn ICU							
55.	UH Surg6IC							
56.	UH NS 3IC	7,875	1,001	7.87	1		8	
57.	RH Ped IC							
58.	Transplant ICU	787,416	3,542	222.31	10		2,223	
59.	Surgical ICU	6,890	2,417	2.85	34		97	
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						61,951	
68.	Ancillary Total (from line 46)						41,907	
69.	Total (Lines 67-68)						103,858	

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2011 To: 12/31/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,203		1,203
Newborn Days			
Total Inpatient Revenue	9,379,793	3	9,379,796
Ancillary Revenue	6,053,923	3	6,053,926
Routine Revenue	3,325,870		3,325,870
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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

BHF Page 3 - Total costs/total charges agree with as filed W/S C

BHF Page 3 - Clinic costs and charges include all cost centers from lines 90.01-90.25