

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: 01/01/2012	To: 12/31/2012	

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 01/01/2012 and ending 12/31/2012 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: 01/01/2012 To: 12/31/2012

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	1,074	393,084		272,028	69.20%		58,283	5.82
2.	Psych	40	14,640		6,804	46.48%		854	7.97
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	80	29,280		21,909	74.83%			
6.	Coronary Care Unit	52	19,032		15,296	80.37%			
7.	Neonatal ICU	47	17,202		8,488	49.34%			
8.	Burn ICU	7	2,562		1,477	57.65%			
9.	UH Surg6IC	18	6,588		5,614	85.22%			
10.	UH NS 3IC	1	366		262	71.58%			
11.	RH Ped IC	35	12,810		9,448	73.75%			
12.	Transplant ICU	8	2,928		2,489	85.01%			
13.	Peds Cancer	10	3,660		2,070	56.56%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				12,100				
22.	Total	1,372	502,152		357,985	71.29%		59,137	5.85
23.	Observation Bed Days				15,243				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				602			140	5.98
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				6				
6.	Coronary Care Unit				21				
7.	Neonatal ICU								
8.	Burn ICU				3				
9.	UH Surg6IC				55				
10.	UH NS 3IC								
11.	RH Ped IC				87				
12.	Transplant ICU								
13.	Peds Cancer				63				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				837	0.23%		140	5.98

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:	01/01/2012	To: 12/31/2012

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	155,112,016	653,020,767	0.237530	2,189,068		519,969	
2.	Recovery Room	12,605,635	64,594,140	0.195151	116,262		22,689	
3.	Delivery and Labor Room							
4.	Anesthesiology	7,902,371	38,692,665	0.204234	96,070		19,621	
5.	Radiology - Diagnostic	82,973,027	581,886,209	0.142593	568,012		80,995	
6.	Radiology - Therapeutic	12,110,085	86,465,413	0.140057	12,253		1,716	
7.	Nuclear Medicine	6,296,017	25,944,635	0.242671	5,900		1,432	
8.	Laboratory	74,808,193	805,596,775	0.092861	1,395,730		129,609	
9.	Blood							
10.	Blood - Administration	17,413,409	80,947,096	0.215121	206,939		44,517	
11.	Intravenous Therapy							
12.	Respiratory Therapy	38,364,779	122,478,525	0.313237	747,903		234,271	
13.	Physical Therapy	16,956,000	65,360,379	0.259423	117,094		30,377	
14.	Occupational Therapy	3,947,258	12,680,435	0.311287	78,181		24,337	
15.	Speech Pathology	7,773,065	13,783,445	0.563942	25,631		14,454	
16.	EKG	5,553,452	62,439,976	0.088941	41,359		3,679	
17.	EEG	9,330,464	33,223,365	0.280840	81,147		22,789	
18.	Med. / Surg. Supplies	43,307,505	107,607,826	0.402457	10,514		4,231	
19.	Drugs Charged to Patients	152,649,812	764,320,852	0.199720	1,501,441		299,868	
20.	Renal Dialysis	15,751,773	36,278,439	0.434191	147,519		64,051	
21.	Ambulance	29,288,611	56,567,355	0.517765				
22.	Endoscopy	3,298,037	22,850,452	0.144331	16,329		2,357	
23.	Pulmonary Function	5,556,406	27,813,095	0.199777	14,406		2,878	
24.	Transplant Immunology	4,331,714	23,374,512	0.185318	7,547		1,399	
25.	BMT Lab	3,228,934	14,017,440	0.230351	7,278		1,676	
26.	Implantable Devices	75,559,990	355,952,930	0.212275				
27.	OP Retail Pharmacy	55,642,611	60,797,881	0.915206				
28.	RN NBN ECMO	1,033,185	1,870,965	0.552220				
29.	Cardiology	13,184,328	83,419,136	0.158049	154,361		24,397	
30.	Psych Other Ancillary	570,421	1,661,754	0.343264				
31.	Cardiac Cath 59.00	4,673,121	25,034,197	0.186669				
32.	Day Surgery	8,387,324	10,423,267	0.804673	1,602		1,289	
33.	Oncology	6,353,571	66	#####				
34.	Cardiac Rehab	939,252	1,540,045	0.609886				
35.	Acquisition	32,013,056	74,038,632	0.432383				
36.	Cardiac Cath 76.03	16,626,737	92,630,531	0.179495	69,499		12,475	
37.	Other Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.								
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	113,197,597	138,275,637	0.818637	6,617		5,417	
44.	Emergency	43,616,470	300,806,138	0.144999	174,107		25,245	
45.	Observation	16,178,920	27,679,320	0.584513	5,797		3,388	
46.	Total				7,798,566		1,599,126	

* 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: 01/01/2012 To: 12/31/2012

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)	304,909,543	7,170,544		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	287,271	6,804		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,061.40	1,053.87		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	602			
3.	Program general inpatient routine cost (Line 1c X Line 2)	638,963			
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)	638,963			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	30,759,080	21,909	1,403.95	6	8,424
9.	Coronary Care Unit	23,381,494	15,296	1,528.60	21	32,101
10.	Neonatal ICU	8,510,852	8,488	1,002.69		
11.	Burn ICU	2,434,327	1,477	1,648.16	3	4,944
12.	UH Surg6IC	8,855,917	5,614	1,577.47	55	86,761
13.	UH NS 3IC	945,362	262	3,608.25		
14.	RH Ped IC	16,855,854	9,448	1,784.07	87	155,214
15.	Transplant ICU	4,037,560	2,489	1,622.16		
16.	Peds Cancer	3,617,509	2,070	1,747.59	63	110,098
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,148,721	12,100	673.45		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,599,126
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,635,631

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: 01/01/2012 To: 12/31/2012

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.	Peds Cancer						
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: 01/01/2012 To: 12/31/2012

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	1,258,147	653,020,767	0.001927	2,189,068		4,218	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	7,627,968	38,692,665	0.197142	96,070		18,939	
5.	Radiology - Diagnostic	117,526	581,886,209	0.000202	568,012		115	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	3,554,048	805,596,775	0.004412	1,395,730		6,158	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,695,228	62,439,976	0.027150	41,359		1,123	
17.	EEG	17,925	33,223,365	0.000540	81,147		44	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	150,982	36,278,439	0.004162	147,519		614	
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	1,661,754	0.902661				
31.	Cardiac Cath 59.00							
32.	Day Surgery							
33.	Oncology							
34.	Cardiac Rehab							
35.	Acquisition	1,778,920	74,038,632	0.024027				
36.	Cardiac Cath 76.03	2,116,938	92,630,531	0.022854	69,499		1,588	
37.	Other Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	3,060,266	138,275,637	0.022132	6,617		146	
44.	Emergency	5,267,933	300,806,138	0.017513	174,107		3,049	
45.	Observation							
46.	Ancillary Total						35,994	

* 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: 01/01/2012 To: 12/31/2012

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	3,664,023	287,271	12.75	602		7,676	
48.	Psych	907,580	6,804	133.39				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU	32,249	8,488	3.80				
54.	Burn ICU	8,021	1,477	5.43	3		16	
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	643,300	9,448	68.09	87		5,924	
58.	Transplant ICU							
59.	Peds Cancer	32,083	2,070	15.50	63		977	
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	26,875	12,100	2.22				
67.	Routine Total (lines 47-66)						14,593	
68.	Ancillary Total (from line 46)						35,994	
69.	Total (Lines 67-68)						50,587	

**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: 01/01/2012 To: 12/31/2012

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)		2,635,631	
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)		50,587	
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)		96,821	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		2,783,039	
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)		7,798,566	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		1,859,230	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		21,002	
F. Coronary Care Unit		71,678	
G. Neonatal ICU			
H. Burn ICU		8,571	
I. UH Surg6IC		187,729	
J. UH NS 3IC			
K. RH Ped IC		1,163,922	
L. Transplant ICU			
M. Peds Cancer		214,764	
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)		11,325,462	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			8,542,423
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: 01/01/2012 To: 12/31/2012

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)	2,783,039	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,783,039	
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)	2,783,039	

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: 01/01/2012 To: 12/31/2012

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)	8,542,423
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)
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: 01/01/2012 To: 12/31/2012

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: 01/01/2012 To: 12/31/2012

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	5,523,734	653,020,767	0.008459	2,189,068		18,517	
2.	Recovery Room	15,361	64,594,140	0.000238	116,262		28	
3.	Delivery and Labor Room							
4.	Anesthesiology	5,844,262	38,692,665	0.151043	96,070		14,511	
5.	Radiology - Diagnostic	6,051,121	581,886,209	0.010399	568,012		5,907	
6.	Radiology - Therapeutic	185,354	86,465,413	0.002144	12,253		26	
7.	Nuclear Medicine							
8.	Laboratory	2,267,251	805,596,775	0.002814	1,395,730		3,928	
9.	Blood							
10.	Blood - Administration	276,494	80,947,096	0.003416	206,939		707	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	68,611	65,360,379	0.001050	117,094		123	
14.	Occupational Therapy							
15.	Speech Pathology	695,331	13,783,445	0.050447	25,631		1,293	
16.	EKG	482,329	62,439,976	0.007725	41,359		319	
17.	EEG	384,020	33,223,365	0.011559	81,147		938	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	262,157	36,278,439	0.007226	147,519		1,066	
21.	Ambulance							
22.	Endoscopy	310,288	22,850,452	0.013579	16,329		222	
23.	Pulmonary Function	367,635	27,813,095	0.013218	14,406		190	
24.	Transplant Immunology	43,010	23,374,512	0.001840	7,547		14	
25.	BMT Lab	101,381	14,017,440	0.007232	7,278		53	
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RN NBN ECMO							
29.	Cardiology	419,862	83,419,136	0.005033	154,361		777	
30.	Psych Other Ancillary							
31.	Cardiac Cath 59.00	97,285	25,034,197	0.003886				
32.	Day Surgery	38,914	10,423,267	0.003733	1,602		6	
33.	Oncology	835,626	66	#####				
34.	Cardiac Rehab							
35.	Acquisition	29,697	74,038,632	0.000401				
36.	Cardiac Cath 76.03							
37.	Other Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.								
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	9,982,454	138,275,637	0.072192	6,617		478	
44.	Emergency	5,543,191	300,806,138	0.018428	174,107		3,208	
45.	Observation							
46.	Ancillary Total						52,311	

* 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: 01/01/2012 To: 12/31/2012

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	16,970,581	287,271	59.08	602		35,566	
48.	Psych	194,570	6,804	28.60				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,520,717	21,909	69.41	6		416	
52.	Coronary Care Unit	658,465	15,296	43.05	21		904	
53.	Neonatal ICU	1,382,470	8,488	162.87				
54.	Burn ICU							
55.	UH Surg6IC	8,193	5,614	1.46	55		80	
56.	UH NS 3IC							
57.	RH Ped IC	819,241	9,448	86.71	87		7,544	
58.	Transplant ICU	7,168	2,489	2.88				
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						44,510	
68.	Ancillary Total (from line 46)						52,311	
69.	Total (Lines 67-68)						96,821	

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2012 To: 12/31/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	837		837
Newborn Days			
Total Inpatient Revenue	11,325,800	(338)	11,325,462
Ancillary Revenue	7,798,904	(338)	7,798,566
Routine Revenue	3,526,896		3,526,896
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 2 - Included the 6 Medicaid Psychiatric days with Adults & Peds to agree with billing and the Paid Claims Report.

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

BHF Page 3-Removed Medicaid charges of \$338 from Cardiac Rehab as Cardiac Rehab is non-covered for Illinois Medicaid.

BHF Page 7 - Included the Medicaid Psychiatric charges with Adults & Peds to agree with billing and the Paid Claims Report.