

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: 01/01/2013	To: 12/31/2013

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 01/01/2013 and ending 12/31/2013 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: 01/01/2013 To: 12/31/2013

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	1,004	366,460		254,847	69.54%		53,771	5.90
2.	Psych	23	8,395		6,528	77.76%		921	7.09
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	73	26,645		20,129	75.55%			
6.	Coronary Care Unit	52	18,980		14,220	74.92%			
7.	Neonatal ICU	35	12,775		8,176	64.00%			
8.	Burn ICU	10	3,650		2,137	58.55%			
9.	UH Surg6IC	18	6,570		4,852	73.85%			
10.	UH NS 3IC								
11.	RH Ped IC	33	12,045		8,591	71.32%			
12.	Transplant ICU	8	2,920		2,526	86.51%			
13.	Peds Cancer	10	3,650		1,757	48.14%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				11,157				
22.	Total	1,266	462,090		334,920	72.48%		54,692	5.92
23.	Observation Bed Days				18,905				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				599			117	7.51
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				7				
6.	Coronary Care Unit				29				
7.	Neonatal ICU								
8.	Burn ICU				11				
9.	UH Surg6IC				3				
10.	UH NS 3IC								
11.	RH Ped IC				217				
12.	Transplant ICU				9				
13.	Peds Cancer				4				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				879	0.26%		117	7.51

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:	01/01/2013	To: 12/31/2013

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)		(4)	(5)	(6)	(7)
1.	Operating Room	144,867,175	677,399,161	0.213858	932,242		199,367	
2.	Recovery Room	12,908,289	73,921,111	0.174622	98,410		17,185	
3.	Delivery and Labor Room	16,247,125	58,007,181	0.280088				
4.	Anesthesiology	6,329,987	43,834,227	0.144407	61,819		8,927	
5.	Radiology - Diagnostic	88,135,056	575,806,314	0.153064	564,085		86,341	
6.	Radiology - Therapeutic	11,527,969	93,025,278	0.123923	4,668		578	
7.	Nuclear Medicine	5,990,993	30,150,311	0.198704	13,577		2,698	
8.	Laboratory	66,153,523	658,604,578	0.100445	1,190,827		119,613	
9.	Blood	15,139,578	74,599,932	0.202944	83,751		16,997	
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	35,858,866	128,729,092	0.278561	582,075		162,143	
13.	Physical Therapy	20,003,229	79,138,764	0.252761	103,741		26,222	
14.	Occupational Therapy	4,106,308	14,850,511	0.276510	56,791		15,703	
15.	Speech Pathology	8,161,044	15,957,682	0.511418	11,306		5,782	
16.	EKG	4,917,973	60,550,329	0.081221	39,462		3,205	
17.	EEG	8,487,056	37,451,982	0.226612	57,838		13,107	
18.	Med. / Surg. Supplies	38,918,758	127,620,689	0.304956	106,024		32,333	
19.	Drugs Charged to Patients	254,758,015	867,065,540	0.293816	1,097,940		322,592	
20.	Renal Dialysis	13,158,969	38,881,481	0.338438	142,173		48,117	
21.	Ambulance	27,146,234	67,798,760	0.400394				
22.	Endoscopy	3,404,415	25,053,228	0.135887				
23.	Pulmonary Function	5,693,341	30,438,390	0.187045	25,847		4,835	
24.	Transplant Immunology	3,821,046	10,991,951	0.347622	9,433		3,279	
25.	BMT Lab	3,259,091	15,806,405	0.206188				
26.	Implantable Devices	68,610,173	388,231,072	0.176725	197,604		34,922	
27.	OP Retail Pharmacy	12,546,260	60,922,783	0.205937				
28.	RN NBN ECMO	914,882	1,707,623	0.535763				
29.	Cardiology	12,212,791	82,907,433	0.147306	112,119		16,516	
30.	Psych Other Ancillary	659,271	2,168,560	0.304013				
31.	Cardiac Cath 59.00	5,689,689	110,317,803	0.051575				
32.	Day Surgery	8,695,050	7,419,725	1.171883				
33.	Oncology							
34.	Cardiac Rehab	785,432	1,093,026	0.718585				
35.	Acquisition 105-110	30,899,679	78,104,302	0.395621	180,468		71,397	
36.	Cardiac Cath 76.03	15,362,270	110,317,803	0.139255	27,238		3,793	
37.	Other Acquisition	6,441,942						
38.	FQHC	5,607,699	3,465,643	1.618083				
39.	HOME DIALY 94.00	3,080,937	13,077,463	0.235591				
40.	HHH 101.00	44,469,971	79,074,743	0.562379				
41.	ECMO-ADULT	39,821	140,942	0.282535				
42.	Hospice	8,139,139	17,228,308	0.472428				
Outpatient Service Cost Centers								
43.	Clinic	87,957,435	155,056,869	0.567259	4,744		2,691	
44.	Emergency	40,825,249	338,578,034	0.120579	246,123		29,677	
45.	Observation	19,043,007	37,132,228	0.512843	30,229		15,503	
46.	Total				5,980,534		1,263,523	

* 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: 01/01/2013 To: 12/31/2013

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)	275,751,043	6,879,898		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	273,752	6,528		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,007.30	1,053.91		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	599			
3.	Program general inpatient routine cost (Line 1c X Line 2)	603,373			
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)	603,373			

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	28,967,627	20,129	1,439.10	7	10,074
9.	Coronary Care Unit	21,895,664	14,220	1,539.78	29	44,654
10.	Neonatal ICU	8,256,575	8,176	1,009.86		
11.	Burn ICU	3,250,848	2,137	1,521.22	11	16,733
12.	UH Surg6IC	7,618,000	4,852	1,570.07	3	4,710
13.	UH NS 3IC					
14.	RH Ped IC	15,658,649	8,591	1,822.68	217	395,522
15.	Transplant ICU	4,210,040	2,526	1,666.68	9	15,000
16.	Peds Cancer	4,623,346	1,757	2,631.39	4	10,526
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	7,558,607	11,157	677.48		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,263,523
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,364,115

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: 01/01/2013 To: 12/31/2013

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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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: 01/01/2013 To: 12/31/2013

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	1,501,971	677,399,161	0.002217	932,242		2,067	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	9,342,332	43,834,227	0.213129	61,819		13,175	
5.	Radiology - Diagnostic	223,127	575,806,314	0.000388	564,085		219	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,362,921	658,604,578	0.003588	1,190,827		4,273	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,902,768	60,550,329	0.031425	39,462		1,240	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	133,956	38,881,481	0.003445	142,173		490	
21.	Ambulance							
22.	Endoscopy							
23.	Pulmonary Function							
24.	Transplant Immunology	41,477	10,991,951	0.003773	9,433		36	
25.	BMT Lab							
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RN NBN ECMO							
29.	Cardiology	60,150	82,907,433	0.000726	112,119		81	
30.	Psych Other Ancillary	1,821,420	2,168,560	0.839921				
31.	Cardiac Cath 59.00							
32.	Day Surgery							
33.	Oncology							
34.	Cardiac Rehab							
35.	Acquisition 105-110	1,615,815	78,104,302	0.020688	180,468		3,734	
36.	Cardiac Cath 76.03	2,706,383	110,317,803	0.024533	27,238		668	
37.	Other Acquisition							
38.	FQHC							
39.	HOME DIALY 94.00							
40.	HHA 101.00	90,743	79,074,743	0.001148				
41.	ECMO-ADULT							
42.	Hospice							
	Outpatient Ancillary Cost Centers							
43.	Clinic	1,651,440	155,056,869	0.010651	4,744		51	
44.	Emergency	5,747,200	338,578,034	0.016975	246,123		4,178	
45.	Observation							
46.	Ancillary Total						30,212	

* 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: 01/01/2013 To: 12/31/2013

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	3,748,701	273,752	13.69	599		8,200	
48.	Psych	997,582	6,528	152.82				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU	32,805	8,176	4.01				
54.	Burn ICU	(729)	2,137	(0.34)	11		(4)	
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	30,680	8,591	3.57	217		775	
58.	Transplant ICU							
59.	Peds Cancer	59,167	1,757	33.68	4		135	
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	169,344	11,157	15.18				
67.	Routine Total (lines 47-66)						9,106	
68.	Ancillary Total (from line 46)						30,212	
69.	Total (Lines 67-68)						39,318	

**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: 01/01/2013 To: 12/31/2013

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		2,364,115	
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)		39,318	
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)		102,214	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		2,505,647	
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 (1)	Program Outpatient (2)
9. Ancillary Services (See Instructions)		5,980,534	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		1,616,750	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		25,326	
F. Coronary Care Unit		104,717	
G. Neonatal ICU		29,576	
H. Burn ICU			
I. UH Surg6IC		10,854	
J. UH NS 3IC			
K. RH Ped IC		966,367	
L. Transplant ICU		28,923	
M. Peds Cancer		9,943	
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)		8,772,990	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			6,267,343
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: 01/01/2013 To: 12/31/2013

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)	2,505,647	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,505,647	
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)	2,505,647	

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: 01/01/2013 To: 12/31/2013

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)	6,267,343
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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2013 To: 12/31/2013

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:	
15-0056		9024	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2013	To: 12/31/2013

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	5,792,222	677,399,161	0.008551	932,242		7,972	
2.	Recovery Room	16,108	73,921,111	0.000218	98,410		21	
3.	Delivery and Labor Room							
4.	Anesthesiology	6,128,329	43,834,227	0.139807	61,819		8,643	
5.	Radiology - Diagnostic	6,345,242	575,806,314	0.011020	564,085		6,216	
6.	Radiology - Therapeutic	194,362	93,025,278	0.002089	4,668		10	
7.	Nuclear Medicine							
8.	Laboratory	2,377,453	658,604,578	0.003610	1,190,827		4,299	
9.	Blood	289,933	74,599,932	0.003887	83,751		326	
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	71,946	79,138,764	0.000909	103,741		94	
14.	Occupational Therapy							
15.	Speech Pathology	729,128	15,957,682	0.045691	11,306		517	
16.	EKG	505,772	60,550,329	0.008353	39,462		330	
17.	EEG	402,685	37,451,982	0.010752	57,838		622	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,366,136	38,881,481	0.035136	142,173		4,995	
21.	Ambulance							
22.	Endoscopy	325,369	25,053,228	0.012987				
23.	Pulmonary Function	385,504	30,438,390	0.012665	25,847		327	
24.	Transplant Immunology	45,101	10,991,951	0.004103	9,433		39	
25.	BMT Lab	106,309	15,806,405	0.006726				
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RN NBN ECMO							
29.	Cardiology	440,269	82,907,433	0.005310	112,119		595	
30.	Psych Other Ancillary							
31.	Cardiac Cath 59.00	102,013	110,317,803	0.000925				
32.	Day Surgery	40,806	7,419,725	0.005500				
33.	Oncology							
34.	Cardiac Rehab							
35.	Acquisition 105-110							
36.	Cardiac Cath 76.03							
37.	Other Acquisition	31,141		#DIV/0!				
38.	FQHC							
39.	HOME DIALY 94.00							
40.	HHA 101.00	491,004	79,074,743	0.006209				
41.	ECMO-ADULT							
42.	Hospice							
	Outpatient Ancillary Centers							
43.	Clinic	11,343,910	155,056,869	0.073160	4,744		347	
44.	Emergency	5,812,625	338,578,034	0.017168	246,123		4,225	
45.	Observation							
46.	Ancillary Total						39,578	

* 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: 01/01/2013 To: 12/31/2013

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	17,795,454	273,752	65.01	599		38,941	
48.	Psych	204,027	6,528	31.25				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,594,633	20,129	79.22	7		555	
52.	Coronary Care Unit	690,471	14,220	48.56	29		1,408	
53.	Neonatal ICU	1,449,666	8,176	177.31				
54.	Burn ICU							
55.	UH Surg6IC	8,591	4,852	1.77	3		5	
56.	UH NS 3IC							
57.	RH Ped IC	859,061	8,591	100.00	217		21,700	
58.	Transplant ICU	7,517	2,526	2.98	9		27	
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						62,636	
68.	Ancillary Total (from line 46)						39,578	
69.	Total (Lines 67-68)						102,214	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2013 To: 12/31/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	879		879
Newborn Days			
Total Inpatient Revenue	8,772,990		8,772,990
Ancillary Revenue	5,980,534		5,980,534
Routine Revenue	2,792,456		2,792,456
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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