

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: 01/01/2014	To: 12/31/2014	

Type of Control

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

Type of Hospital

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

Health Care Program

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

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Indiana University Health 9024 for the cost report beginning 01/01/2014 and ending 12/31/2014 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: 01/01/2014 To: 12/31/2014

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	962	351,145		247,345	70.44%		48,746	6.34
2.	Psych	28	10,220		6,482	63.42%		921	7.04
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		19,112	79.34%			
6.	Coronary Care Unit	52	18,980		14,365	75.68%			
7.	Neonatal ICU	44	16,060		9,059	56.41%			
8.	Burn ICU	10	3,650		2,231	61.12%			
9.	UH Surg6IC	18	6,570		3,920	59.67%			
10.	UH NS 3IC								
11.	RH Ped IC	42	15,330		7,587	49.49%			
12.	Transplant ICU	8	2,920		3,036	103.97%			
13.	Peds Cancer	11	4,015		2,471	61.54%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				6,030				
22.	Total	1,241	452,980		321,638	71.00%		49,667	6.35
23.	Observation Bed Days				15,760				

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program								
1. Adults and Pediatrics				576			92	7.83
2. Psych								
3. Rehab								
4. Other (Sub)								
5. Intensive Care Unit				14				
6. Coronary Care Unit				32				
7. Neonatal ICU				1				
8. Burn ICU				31				
9. UH Surg6IC								
10. UH NS 3IC								
11. RH Ped IC				65				
12. Transplant ICU				1				
13. Peds Cancer								
14. Other								
16. Other								
17. Other								
18. Other								
19. Other								
20. Other								
21. Newborn Nursery								
22. Total				720	0.22%		92	7.83

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: 01/01/2014	To: 12/31/2014

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	97,099,146	741,984,304	0.130864	1,391,416		182,086	
2.	Recovery Room	14,445,455	96,438,172	0.149790	103,862		15,557	
3.	Delivery and Labor Room	11,876,368	43,049,054	0.275880				
4.	Anesthesiology	5,254,230	55,126,095	0.095313	68,784		6,556	
5.	Radiology - Diagnostic	79,039,747	532,092,189	0.148545	610,352		90,665	
6.	Radiology - Therapeutic	11,640,248	118,385,266	0.098325				
7.	Nuclear Medicine	2,926,489	26,820,429	0.109114	7,531		822	
8.	Laboratory	76,773,796	689,335,767	0.111374	884,042		98,459	
9.	Blood	24,221,536	72,540,570	0.333903	99,699		33,290	
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	29,919,607	117,482,129	0.254674	198,957		50,669	
13.	Physical Therapy	19,897,684	66,618,489	0.298681	106,561		31,828	
14.	Occupational Therapy	4,274,757	13,846,899	0.308716	52,001		16,054	
15.	Speech Pathology	6,140,057	19,039,567	0.322489	44,550		14,367	
16.	EKG	5,982,422	88,364,039	0.067702	73,280		4,961	
17.	EEG	7,901,056	47,697,348	0.165650	79,366		13,147	
18.	Med. / Surg. Supplies	56,482,207	153,165,516	0.368766	7,755		2,860	
19.	Drugs Charged to Patients	186,987,814	893,613,948	0.209249	917,791		192,047	
20.	Renal Dialysis	13,012,082	35,359,677	0.367992	21,585		7,943	
21.	Ambulance	30,347,324	98,802,991	0.307150				
22.	Endoscopy (50.01)	3,114,907	25,154,274	0.123832	32,226		3,991	
23.	Pulmonary Function(53.01)	5,303,228	29,594,421	0.179197	4,462		800	
24.	Transplant Immunology(60.01)	3,675,500	15,964,014	0.230237	2,544		586	
25.	BMT Lab	34						
26.	Implantable Devices	113,962,259	387,332,952	0.294223				
27.	OP Retail Pharmacy	63,445,661	58,013,674	1.093633				
28.	RH NBN ECMO(76.00)	1,411,684	2,862,299	0.493199				
29.	Cardiology(76.01)	4,383,166	32,973,969	0.132928	17,194		2,286	
30.	Psych (76.02)	725,075	3,141,847	0.230780	20,803		4,801	
31.	Cardiac Cath 59.00	2,836,090	44,268,802	0.064065				
32.	Day Surgery(76.04)	6,042,370	3,834,424	1.575822	1,691		2,665	
33.	Oncology							
34.	Cardiac Rehab(76.97)	877,958	1,043,638	0.841248				
35.	Acquisition 105-110	34,203,753	99,743,353	0.342918				
36.	Cardiac Cath 76.03	13,300,154	126,159,900	0.105423				
37.	Other Acqisition(112-112.01)	5,249,643						
38.	FQHC	4,704,169	3,641,127	1.291954				
39.	HOME DIALY 94.00	2,241,565	16,443,327	0.136321				
40.	HHH 101.00	42,959,724	85,844,514	0.500436				
41.	ECMO-ADULT(76.08)	805,054	3,256,588	0.247208				
42.	Hospice	8,360,921	15,357,440	0.544422				
Outpatient Service Cost Centers								
43.	Clinic	82,182,425	172,893,437	0.475336	1,977		940	
44.	Emergency	39,525,345	427,551,352	0.092446	215,536		19,925	
45.	Observation	14,906,754	35,956,512	0.414577				
46.	Total				4,963,965		797,305	

* 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: 01/01/2014 To: 12/31/2014

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)	248,860,360	6,780,208		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	263,105	6,482		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	945.86	1,046.01		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	576			
3.	Program general inpatient routine cost (Line 1c X Line 2)	544,815			
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)	544,815			

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	25,536,451	19,112	1,336.15	14	18,706
9.	Coronary Care Unit	21,908,876	14,365	1,525.16	32	48,805
10.	Neonatal ICU	7,823,140	9,059	863.58	1	864
11.	Burn ICU	3,316,911	2,231	1,486.74	31	46,089
12.	UH Surg6IC	5,549,440	3,920	1,415.67		
13.	UH NS 3IC					
14.	RH Ped IC	13,943,367	7,587	1,837.80	65	119,457
15.	Transplant ICU	3,888,022	3,036	1,280.64	1	1,281
16.	Peds Cancer	4,379,787	2,471	1,772.48		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	6,231,572	6,030	1,033.43		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					797,305
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,577,322

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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014

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	537,589	741,984,304	0.000725	1,391,416		1,009	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	8,966,212	55,126,095	0.162649	68,784		11,188	
5.	Radiology - Diagnostic	180,234	532,092,189	0.000339	610,352		207	
6.	Radiology - Therapeutic	447,488	118,385,266	0.003780				
7.	Nuclear Medicine							
8.	Laboratory	2,511,379	689,335,767	0.003643	884,042		3,221	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,706,350	88,364,039	0.019310	73,280		1,415	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	13,423	98,802,991	0.000136				
22.	Endoscopy (50.01)							
23.	Pulmonary Function(53.01)							
24.	Transplant Immunology(60.01)	281,167	15,964,014	0.017613	2,544		45	
25.	BMT Lab							
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RH NBN ECMO(76.00)							
29.	Cardiology(76.01)	280,150	32,973,969	0.008496	17,194		146	
30.	Psych (76.02)	1,800,229	3,141,847	0.572984	20,803		11,920	
31.	Cardiac Cath 59.00							
32.	Day Surgery(76.04)							
33.	Oncology							
34.	Cardiac Rehab(76.97)							
35.	Acquisition 105-110	1,504,649	99,743,353	0.015085				
36.	Cardiac Cath 76.03	2,110,012	126,159,900	0.016725				
37.	Other Acquisition(112-112.01)							
38.	FQHC							
39.	HOME DIALY 94.00							
40.	HHH 101.00							
41.	ECMO-ADULT(76.08)							
42.	Hospice							
	Outpatient Ancillary Cost Centers							
43.	Clinic	1,251,200	172,893,437	0.007237	1,977		14	
44.	Emergency	5,645,848	427,551,352	0.013205	215,536		2,846	
45.	Observation							
46.	Ancillary Total						32,011	

* 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: 01/01/2014 To: 12/31/2014

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	1,845,408	263,105	7.01	576		4,038	
48.	Psych	675,000	6,482	104.13				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU	39,438	9,059	4.35	1		4	
54.	Burn ICU	8,750	2,231	3.92	31		122	
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	1,553,249	7,587	204.73	65		13,307	
58.	Transplant ICU							
59.	Peds Cancer	12,500	2,471	5.06				
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						17,471	
68.	Ancillary Total (from line 46)						32,011	
69.	Total (Lines 67-68)						49,482	

**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: 01/01/2014 To: 12/31/2014	
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)	1,577,322	
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)	49,482	
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)	55,097	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,681,901	
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)	4,963,965	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,652,677	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	51,167	
	F. Coronary Care Unit	116,876	
	G. Neonatal ICU	3,714	
	H. Burn ICU	177,075	
	I. UH Surg6IC		
	J. UH NS 3IC		
	K. RH Ped IC	222,622	
	L. Transplant ICU	4,523	
	M. Peds Cancer		
	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)	7,192,619	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,510,718
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: 01/01/2014 To: 12/31/2014

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	1,681,901	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,681,901	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	1,681,901	

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: 01/01/2014 To: 12/31/2014

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)	5,510,718
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: 01/01/2014 To: 12/31/2014

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: 01/01/2014 To: 12/31/2014

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	3,840,734	741,984,304	0.005176	1,391,416		7,202	
2.	Recovery Room	162,496	96,438,172	0.001685	103,862		175	
3.	Delivery and Labor Room	237,433	43,049,054	0.005515				
4.	Anesthesiology	4,416,569	55,126,095	0.080118	68,784		5,511	
5.	Radiology - Diagnostic	3,204,162	532,092,189	0.006022	610,352		3,676	
6.	Radiology - Therapeutic	115,167	118,385,266	0.000973				
7.	Nuclear Medicine							
8.	Laboratory	1,413,554	689,335,767	0.002051	884,042		1,813	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology	64,683	19,039,567	0.003397	44,550		151	
16.	EKG	373,897	88,364,039	0.004231	73,280		310	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	132,521	35,359,677	0.003748	21,585		81	
21.	Ambulance							
22.	Endoscopy (50.01)	120,688	25,154,274	0.004798	32,226		155	
23.	Pulmonary Function(53.01)	100,180	29,594,421	0.003385	4,462		15	
24.	Transplant Immunology(60.01)	9,465	15,964,014	0.000593	2,544		2	
25.	BMT Lab							
26.	Implantable Devices							
27.	OP Retail Pharmacy							
28.	RH NBN ECMO(76.00)							
29.	Cardiology(76.01)	911,869	32,973,969	0.027654	17,194		475	
30.	Psych (76.02)							
31.	Cardiac Cath 59.00	73,359	44,268,802	0.001657				
32.	Day Surgery(76.04)	84,403	3,834,424	0.022012	1,691		37	
33.	Oncology							
34.	Cardiac Rehab(76.97)							
35.	Acquisition 105-110							
36.	Cardiac Cath 76.03							
37.	Other Acquisition(112-112.01)							
38.	FQHC	45,751	3,641,127	0.012565				
39.	HOME DIALY 94.00							
40.	HHA 101.00							
41.	ECMO-ADULT(76.08)							
42.	Hospice							
	Outpatient Ancillary Centers							
43.	Clinic	8,067,988	172,893,437	0.046665	1,977		92	
44.	Emergency	3,234,137	427,551,352	0.007564	215,536		1,630	
45.	Observation							
46.	Ancillary Total						21,325	

* 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: 01/01/2014 To: 12/31/2014

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	14,406,107	263,105	54.75	576		31,536	
48.	Psych	66,260	6,482	10.22				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,863,967	19,112	97.53	14		1,365	
52.	Coronary Care Unit	66,260	14,365	4.61	32		148	
53.	Neonatal ICU	424,382	9,059	46.85	1		47	
54.	Burn ICU	29,187	2,231	13.08	31		405	
55.	UH Surg6IC	140,408	3,920	35.82				
56.	UH NS 3IC							
57.	RH Ped IC	31,553	7,587	4.16	65		270	
58.	Transplant ICU	3,944	3,036	1.30	1		1	
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						33,772	
68.	Ancillary Total (from line 46)						21,325	
69.	Total (Lines 67-68)						55,097	

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	720		720
Newborn Days			
Total Inpatient Revenue	7,192,619		7,192,619
Ancillary Revenue	4,963,965		4,963,965
Routine Revenue	2,228,654		2,228,654
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]