

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: 01/01/2019	To: 12/31/2019	

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	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

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 01/01/2019 and ending 12/31/2019 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: 01/01/2019 To: 12/31/2019

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	931	339,860		229,714	67.59%		47,285	6.69
2.	Psych	24	8,760		5,236	59.77%		712	7.35
3.	Rehab	3	1,050		855	81.43%		47	18.19
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		18,057	74.96%			
6.	Coronary Care Unit	64	23,360		16,309	69.82%			
7.	Neonatal ICU	98	35,770		30,462	85.16%			
8.	Burn ICU	10	3,650		2,206	60.44%			
9.	UH Surg6IC	18	6,570		4,044	61.55%			
10.	UH NS 3IC								
11.	RH Ped IC	36	13,140		10,161	77.33%			
12.	Transplant ICU	8	2,920		2,035	69.69%			
13.	Peds Cancer	12	4,380		3,198	73.01%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				4,797				
22.	Total	1,270	463,550		327,074	70.56%		48,044	6.71
23.	Observation Bed Days				18,062				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				542			66	11.30
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				111				
6.	Coronary Care Unit				30				
7.	Neonatal ICU				18				
8.	Burn ICU								
9.	UH Surg6IC				1				
10.	UH NS 3IC								
11.	RH Ped IC				44				
12.	Transplant ICU								
13.	Peds Cancer								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				746	0.23%		66	11.30

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:	01/01/2019	To: 12/31/2019

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	126,986,678	#####	0.116336	1,371,600		159,566	
2.	Recovery Room	19,601,084	141,623,828	0.138402	69,744		9,653	
3.	Delivery and Labor Room	13,013,041	57,854,771	0.224926	21,365		4,806	
4.	Anesthesiology	8,800,442	84,690,768	0.103913	111,722		11,609	
5.	Radiology - Diagnostic	88,909,140	603,394,775	0.147348	1,040,986		153,387	
6.	Radiology - Therapeutic	16,405,435	187,782,652	0.087364				
7.	Nuclear Medicine	4,280,884	54,200,898	0.078982	4,151		328	
8.	Laboratory	98,882,334	567,391,425	0.174275	488,195		85,080	
9.	Blood							
10.	Blood - Administration	15,282,999	110,998,986	0.137686	130,199		17,927	
11.	Intravenous Therapy							
12.	Respiratory Therapy	37,376,875	156,211,154	0.239271	383,081		91,660	
13.	Physical Therapy	30,233,217	81,753,871	0.369808	109,020		40,316	
14.	Occupational Therapy	6,359,343	22,922,451	0.277429	56,203		15,592	
15.	Speech Pathology	8,652,962	26,071,156	0.331898	31,384		10,416	
16.	EKG	6,635,919	89,248,489	0.074353	107,015		7,957	
17.	EEG	12,080,413	58,459,865	0.206645	59,377		12,270	
18.	Med. / Surg. Supplies	88,258,179	340,103,600	0.259504	377,633		97,997	
19.	Drugs Charged to Patients	335,036,761	#####	0.208231	1,287,878		268,176	
20.	Renal Dialysis	9,550,995	36,074,928	0.264754	50,489		13,367	
21.	Ambulance	46,684,201	227,023,432	0.205636				
22.	Endoscopy (50.01)	3,781,096	34,677,748	0.109035	32,815		3,578	
23.	Pulmonary Function(53.01)	6,998,130	39,051,603	0.179202	2,766		496	
24.	Cardiac Cath 59.00	3,434,866	50,776,513	0.067647	5,327		360	
25.	TXPLT Immun	3,268,824	15,235,375	0.214555				
26.	BMT LAB							
27.	Implmt Dev Charged	145,248,982	594,740,183	0.244223	415,760		101,538	
28.	OP RTL Pharm	189,840,098	205,788,772	0.922500				
29.	RN NBN ECMO	1,923,389	4,311,470	0.446110				
30.	CARDIOLOGY	3,849,054	57,745,142	0.066656	185,348		12,355	
31.	PSYCH OTH	1,714,737	998,140	1.717932				
32.	Cardiac Cath 76.03	14,365,276	171,903,330	0.083566	56,396		4,713	
33.	Day Surgery	8,952,974	17,469,415	0.512494				
34.	ECMO - ADULT	2,514,649	12,428,619	0.202327				
35.	Card Rehabilitation	1,416,179	3,953,507	0.358208				
36.	FQHC							
37.	Home Dialysis							
38.	HHA	83,482,923	209,447,145	0.398587				
39.	Organ ACQ	38,318,239	58,353,581	0.656656				
40.	Other ACQ CST	7,423,656						
41.	Hospice							
42.								
Outpatient Service Cost Centers								
43.	Clinic	68,765,318	247,756,922	0.277552	41,883		11,625	
44.	Emergency	60,769,120	636,435,768	0.095484	325,602		31,090	
45.	Observation	19,823,767	100,521,851	0.197209				
46.	Total				6,765,939		1,165,862	

* 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: 01/01/2019 To: 12/31/2019

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)	271,945,188	8,241,922	1,109,777	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	247,776	5,236	855	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,097.54	1,574.09	1,297.98	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	542			
3.	Program general inpatient routine cost (Line 1c X Line 2)	594,867			
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)	594,867			

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	28,845,748	18,057	1,597.48	111	177,320
9.	Coronary Care Unit	31,204,177	16,309	1,913.31	30	57,399
10.	Neonatal ICU	40,598,509	30,462	1,332.76	18	23,990
11.	Burn ICU	4,258,960	2,206	1,930.63		
12.	UH Surg6IC	7,540,142	4,044	1,864.53	1	1,865
13.	UH NS 3IC					
14.	RH Ped IC	20,003,830	10,161	1,968.69	44	86,622
15.	Transplant ICU	4,068,744	2,035	1,999.38		
16.	Peds Cancer	5,498,583	3,198	1,719.38		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,544,792	4,797	530.50		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,165,862
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,107,925

**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: 01/01/2019 To: 12/31/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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: 01/01/2019 To: 12/31/2019

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	7,473,473	#####	0.006847	1,371,600		9,391	
2.	Recovery Room							
3.	Delivery and Labor Room	675,179	57,854,771	0.011670	21,365		249	
4.	Anesthesiology	15,462,307	84,690,768	0.182574	111,722		20,398	
5.	Radiology - Diagnostic	3,777,574	603,394,775	0.006261	1,040,986		6,518	
6.	Radiology - Therapeutic	3,334,586	187,782,652	0.017758				
7.	Nuclear Medicine	189,976	54,200,898	0.003505	4,151		15	
8.	Laboratory	871,927	567,391,425	0.001537	488,195		750	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,634,902	89,248,489	0.029523	107,015		3,159	
17.	EEG	294,445	58,459,865	0.005037	59,377		299	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	147,653	227,023,432	0.000650				
22.	Endoscopy (50.01)							
23.	Pulmonary Function(53.01)							
24.	Cardiac Cath 59.00							
25.	TXPLT Immun							
26.	BMT LAB							
27.	Implmt Dev Charged							
28.	OP RTL Pharm							
29.	RN NBN ECMO							
30.	CARDIOLOGY							
31.	PSYCH OTH	969,018	998,140	0.970824				
32.	Cardiac Cath 76.03	2,805,568	171,903,330	0.016321	56,396		920	
33.	Day Surgery							
34.	ECMO - ADULT							
35.	Card Rehabilitation							
36.	FQHC							
37.	Home Dialysis							
38.	HHA							
39.	Organ ACQ	2,650,861	58,353,581	0.045428				
40.	Other ACQ CST							
41.	Hospice							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	6,440,355	247,756,922	0.025995	41,883		1,089	
44.	Emergency	11,813,112	636,435,768	0.018561	325,602		6,043	
45.	Observation							
46.	Ancillary Total						48,831	

* 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: 01/01/2019 To: 12/31/2019

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	28,455,253	247,776	114.84	542		62,243	
48.	Psych	855,000	5,236	163.29				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	477,148	16,309	29.26	30		878	
53.	Neonatal ICU							
54.	Burn ICU							
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	2,478,073	10,161	243.88	44		10,731	
58.	Transplant ICU							
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						73,852	
68.	Ancillary Total (from line 46)						48,831	
69.	Total (Lines 67-68)						122,683	

**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: 01/01/2019 To: 12/31/2019	
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)	2,107,925	
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)	122,683	
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	181,233	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,411,841	
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)	6,765,939	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,895,125	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	690,446	
	F. Coronary Care Unit	167,463	
	G. Neonatal ICU	107,424	
	H. Burn ICU		
	I. UH Surg6IC	7,062	
	J. UH NS 3IC		
	K. RH Ped IC	166,151	
	L. Transplant ICU		
	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)	9,799,610	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		7,387,769
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: 01/01/2019 To: 12/31/2019

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)	2,411,841	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,411,841	
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)	2,411,841	

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:	Medicaid Provider Number:
15-0056	9024
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2019 To: 12/31/2019

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)	7,387,769
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: 01/01/2019 To: 12/31/2019

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

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(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:	To:
		01/01/2019	12/31/2019

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	11,131,417	#####	0.010198	1,371,600		13,988	
2.	Recovery Room	430,333	141,623,828	0.003039	69,744		212	
3.	Delivery and Labor Room	353,347	57,854,771	0.006107	21,365		130	
4.	Anesthesiology	9,052,788	84,690,768	0.106892	111,722		11,942	
5.	Radiology - Diagnostic	8,235,550	603,394,775	0.013649	1,040,986		14,208	
6.	Radiology - Therapeutic	23,688	187,782,652	0.000126				
7.	Nuclear Medicine							
8.	Laboratory	4,098,035	567,391,425	0.007223	488,195		3,526	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	61,194	156,211,154	0.000392	383,081		150	
13.	Physical Therapy	80,934	81,753,871	0.000990	109,020		108	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,018,587	89,248,489	0.011413	107,015		1,221	
17.	EEG	2,512,909	58,459,865	0.042985	59,377		2,552	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	217,141	36,074,928	0.006019	50,489		304	
21.	Ambulance							
22.	Endoscopy (50.01)							
23.	Pulmonary Function(53.01)	146,077	39,051,603	0.003741	2,766		10	
24.	Cardiac Cath 59.00	183,583	50,776,513	0.003616	5,327		19	
25.	TXPLT Immun							
26.	BMT LAB							
27.	Implmt Dev Charged							
28.	OP RTL Pharm							
29.	RN NBN ECMO							
30.	CARDIOLOGY	1,764,760	57,745,142	0.030561	185,348		5,664	
31.	PSYCH OTH							
32.	Cardiac Cath 76.03	276,361	171,903,330	0.001608	56,396		91	
33.	Day Surgery	163,843	17,469,415	0.009379				
34.	ECMO - ADULT							
35.	Card Rehabilitation							
36.	FQHC							
37.	Home Dialysis							
38.	HHA							
39.	Organ ACQ							
40.	Other ACQ CST							
41.	Hospice							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	6,834,008	247,756,922	0.027584	41,883		1,155	
44.	Emergency	10,479,994	636,435,768	0.016467	325,602		5,362	
45.	Observation							
46.	Ancillary Total						60,642	

* 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: 01/01/2019 To: 12/31/2019

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	37,393,583	247,776	150.92	542		81,799	
48.	Psych	434,282	5,236	82.94				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,842,235	18,057	268.16	111		29,766	
52.	Coronary Care Unit	203,322	16,309	12.47	30		374	
53.	Neonatal ICU	1,760,813	30,462	57.80	18		1,040	
54.	Burn ICU	49,351	2,206	22.37				
55.	UH Surg6IC	221,088	4,044	54.67	1		55	
56.	UH NS 3IC							
57.	RH Ped IC	1,745,021	10,161	171.74	44		7,557	
58.	Transplant ICU	213,192	2,035	104.76				
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	219,115	4,797	45.68				
67.	Routine Total (lines 47-66)						120,591	
68.	Ancillary Total (from line 46)						60,642	
69.	Total (Lines 67-68)						181,233	

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: 01/01/2019 To: 12/31/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	746		746
Newborn Days			
Total Inpatient Revenue	9,799,611	(1)	9,799,610
Ancillary Revenue	6,765,940	(1)	6,765,939
Routine Revenue	3,033,671		3,033,671
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

BHF Page 3 - Clinic is Medicare lines 90.01-90.24.