

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: 01/01/2020	To: 12/31/2020	

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 _____	☐ _____
☐ 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 01/01/2020 and ending 12/31/2020 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: 01/01/2020 To: 12/31/2020

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	340,740		222,367	65.26%		44,898	6.86
2.	Psych	24	8,784		4,294	48.88%		538	7.98
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,156		19,329	80.02%			
6.	Coronary Care Unit	66	23,976		17,786	74.18%			
7.	Neonatal ICU	98	35,868		29,108	81.15%			
8.	Burn ICU	10	3,660		1,841	50.30%			
9.	UH Surg6IC	18	6,588		3,362	51.03%			
10.	UH NS 3IC								
11.	RH Ped IC	38	13,728		8,677	63.21%			
12.	Transplant ICU	8	2,928		2,057	70.25%			
13.	Peds Cancer	12	4,392		3,348	76.23%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				4,092				
22.	Total	1,271	464,820		316,261	68.04%		45,436	6.87
23.	Observation Bed Days				13,902				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				148			25	11.08
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit				22				
7.	Neonatal ICU				73				
8.	Burn ICU				16				
9.	UH Surg6IC								
10.	UH NS 3IC								
11.	RH Ped IC				18				
12.	Transplant ICU								
13.	Peds Cancer								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				277	0.09%		25	11.08

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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	121,119,598	#####	0.116225	516,481		60,028	
2.	Recovery Room	18,425,265	124,011,906	0.148577	39,040		5,800	
3.	Delivery and Labor Room	14,103,391	54,676,551	0.257942				
4.	Anesthesiology	8,584,765	81,021,710	0.105956	36,540		3,872	
5.	Radiology - Diagnostic	88,017,621	589,300,702	0.149359	217,578		32,497	
6.	Radiology - Therapeutic	14,913,736	174,115,481	0.085654				
7.	Nuclear Medicine	4,315,677	51,521,535	0.083765				
8.	Laboratory	81,941,541	514,073,335	0.159397	362,155		57,726	
9.	Blood							
10.	Blood - Administration	17,326,821	107,666,370	0.160931	442,557		71,221	
11.	Intravenous Therapy							
12.	Respiratory Therapy	38,939,725	168,019,048	0.231758	254,030		58,873	
13.	Physical Therapy	34,701,019	78,822,077	0.440245	18,022		7,934	
14.	Occupational Therapy	6,979,683	20,734,695	0.336619	14,106		4,748	
15.	Speech Pathology	9,294,888	24,364,804	0.381488	10,338		3,944	
16.	EKG	7,812,483	88,374,213	0.088402	89,689		7,929	
17.	EEG	12,272,904	60,711,170	0.202152	113,779		23,001	
18.	Med. / Surg. Supplies	91,771,256	343,431,888	0.267218	71,754		19,174	
19.	Drugs Charged to Patients	334,702,241	#####	0.195863	627,188		122,843	
20.	Renal Dialysis	9,733,826	37,216,503	0.261546	104,475		27,325	
21.	Ambulance	47,749,477	224,948,716	0.212268				
22.	Endoscopy (50.01)	3,840,561	31,830,772	0.120656				
23.	Pulmonary Function(53.01)	6,802,342	33,096,245	0.205532				
24.	Cardiac Cath 59.00	3,423,637	44,612,622	0.076741				
25.	TXPLT Immun	3,385,878	14,840,335	0.228154				
26.	BMT LAB							
27.	Implmt Dev Charged	140,485,837	581,849,429	0.241447	77,927		18,815	
28.	OP RTL Pharm	265,578,359	280,774,511	0.945878				
29.	RN NBN ECMO	2,072,732	5,819,828	0.356150	578,354		205,981	
30.	CARDIOLOGY	4,520,249	66,223,413	0.068258	2,719		186	
31.	PSYCH OTH	2,017,192	1,376	#####				
32.	Cardiac Cath 76.03	14,876,322	149,997,760	0.099177	78,895		7,825	
33.	Day Surgery	8,314,393	23,912,579	0.347700				
34.	ECMO - ADULT	3,939,215	22,654,703	0.173881				
35.	Card Rehabilitation	1,435,109	3,212,309	0.446753				
36.	FQHC							
37.	Home Dialysis							
38.	HHA	95,778,544	253,487,186	0.377844				
39.	Organ ACQ	41,602,984	63,020,396	0.660151				
40.	Other ACQ CST							
41.	Hospice							
42.								
Outpatient Service Cost Centers								
43.	Clinic	70,658,940	213,923,264	0.330300				
44.	Emergency	60,365,139	597,020,714	0.101111	140,439		14,200	
45.	Observation	17,212,483	93,776,363	0.183548				
46.	Total				3,796,066		753,922	

* 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: 01/01/2020 To: 12/31/2020

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)	292,531,138	7,437,947		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	236,269	4,294		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,238.13	1,732.17		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	148			
3.	Program general inpatient routine cost (Line 1c X Line 2)	183,243			
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)	183,243			

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	31,324,881	19,329	1,620.62		
9.	Coronary Care Unit	35,487,841	17,786	1,995.27	22	43,896
10.	Neonatal ICU	41,759,157	29,108	1,434.63	73	104,728
11.	Burn ICU	4,454,435	1,841	2,419.57	16	38,713
12.	UH Surg6IC	7,979,678	3,362	2,373.49		
13.	UH NS 3IC					
14.	RH Ped IC	19,212,380	8,677	2,214.17	18	39,855
15.	Transplant ICU	4,494,597	2,057	2,185.03		
16.	Peds Cancer	5,939,310	3,348	1,773.99		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,430,399	4,092	593.94		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					753,922
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,164,357

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: 01/01/2020 To: 12/31/2020

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: 01/01/2020 To: 12/31/2020

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	7,273,629	#####	0.006980	516,481		3,605	
2.	Recovery Room							
3.	Delivery and Labor Room	675,179	54,676,551	0.012349				
4.	Anesthesiology	17,245,757	81,021,710	0.212854	36,540		7,778	
5.	Radiology - Diagnostic	34,693	589,300,702	0.000059	217,578		13	
6.	Radiology - Therapeutic	3,067,180	174,115,481	0.017616				
7.	Nuclear Medicine	102,112	51,521,535	0.001982				
8.	Laboratory	1,927,744	514,073,335	0.003750	362,155		1,358	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,244,177	88,374,213	0.025394	89,689		2,278	
17.	EEG	867,190	60,711,170	0.014284	113,779		1,625	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	147,659	224,948,716	0.000656				
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	1,105,059	1,376	803.095203				
32.	Cardiac Cath 76.03	2,476,881	149,997,760	0.016513	78,895		1,303	
33.	Day Surgery							
34.	ECMO - ADULT							
35.	Card Rehabilitation							
36.	FQHC							
37.	Home Dialysis							
38.	HHA							
39.	Organ ACQ	2,592,754	63,020,396	0.041142				
40.	Other ACQ CST							
41.	Hospice							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	6,941,855	213,923,264	0.032450				
44.	Emergency	12,162,873	597,020,714	0.020373	140,439		2,861	
45.	Observation							
46.	Ancillary Total						20,821	

* 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: 01/01/2020 To: 12/31/2020

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	30,764,615	236,269	130.21	148		19,271	
48.	Psych	855,000	4,294	199.12				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	552,593	17,786	31.07	22		684	
53.	Neonatal ICU							
54.	Burn ICU							
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	2,626,783	8,677	302.73	18		5,449	
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)						25,404	
68.	Ancillary Total (from line 46)						20,821	
69.	Total (Lines 67-68)						46,225	

**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: 01/01/2020 To: 12/31/2020

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)	1,164,357	
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)	46,225	
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)	58,169	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,268,751	
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)	3,796,066	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	564,391	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit	155,364	
	G. Neonatal ICU	436,746	
	H. Burn ICU	47,500	
	I. UH Surg6IC		
	J. UH NS 3IC		
	K. RH Ped IC	127,116	
	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)	5,127,183	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,858,432
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: 01/01/2020 To: 12/31/2020

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)	1,268,751	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,268,751	
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)	1,268,751	

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: 01/01/2020 To: 12/31/2020

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)	3,858,432
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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: 01/01/2020	To: 12/31/2020

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	10,978,310	#####	0.010535	516,481		5,441	
2.	Recovery Room	440,699	124,011,906	0.003554	39,040		139	
3.	Delivery and Labor Room	119,479	54,676,551	0.002185				
4.	Anesthesiology	9,145,000	81,021,710	0.112871	36,540		4,124	
5.	Radiology - Diagnostic	7,074,694	589,300,702	0.012005	217,578		2,612	
6.	Radiology - Therapeutic	101,850	174,115,481	0.000585				
7.	Nuclear Medicine							
8.	Laboratory	4,187,623	514,073,335	0.008146	362,155		2,950	
9.	Blood							
10.	Blood - Administration	33,298	107,666,370	0.000309	442,557		137	
11.	Intravenous Therapy							
12.	Respiratory Therapy	64,636	168,019,048	0.000385	254,030		98	
13.	Physical Therapy	70,512	78,822,077	0.000895	18,022		16	
14.	Occupational Therapy	48,967	20,734,695	0.002362	14,106		33	
15.	Speech Pathology							
16.	EKG	1,206,537	88,374,213	0.013653	89,689		1,225	
17.	EEG	2,898,822	60,711,170	0.047748	113,779		5,433	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	399,567	37,216,503	0.010736	104,475		1,122	
21.	Ambulance							
22.	Endoscopy (50.01)							
23.	Pulmonary Function(53.01)	156,693	33,096,245	0.004734				
24.	Cardiac Cath 59.00	197,825	44,612,622	0.004434				
25.	TXPLT Immun							
26.	BMT LAB							
27.	Implmt Dev Charged							
28.	OP RTL Pharm							
29.	RN NBN ECMO							
30.	CARDIOLOGY	1,629,608	66,223,413	0.024608	2,719		67	
31.	PSYCH OTH							
32.	Cardiac Cath 76.03							
33.	Day Surgery	97,933	23,912,579	0.004095				
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	4,971,091	213,923,264	0.023238				
44.	Emergency	10,171,340	597,020,714	0.017037	140,439		2,393	
45.	Observation							
46.	Ancillary Total						25,790	

* 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: 01/01/2020 To: 12/31/2020

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	38,701,236	236,269	163.80	148		24,242	
48.	Psych	242,875	4,294	56.56				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,542,141	19,329	234.99				
52.	Coronary Care Unit	225,246	17,786	12.66	22		279	
53.	Neonatal ICU	1,825,474	29,108	62.71	73		4,578	
54.	Burn ICU	23,504	1,841	12.77	16		204	
55.	UH Surg6IC	213,495	3,362	63.50				
56.	UH NS 3IC							
57.	RH Ped IC	1,482,708	8,677	170.88	18		3,076	
58.	Transplant ICU	182,156	2,057	88.55				
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	191,949	4,092	46.91				
67.	Routine Total (lines 47-66)						32,379	
68.	Ancillary Total (from line 46)						25,790	
69.	Total (Lines 67-68)						58,169	

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: 01/01/2020 To: 12/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	277		277
Newborn Days			
Total Inpatient Revenue	5,127,184	(1)	5,127,183
Ancillary Revenue	3,796,067	(1)	3,796,066
Routine Revenue	1,331,117		1,331,117
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.

BHF Page 2 - Changed the total bed days for Peds Cancer to agree with W/S S-3

BHF Page 2 - The length of stay for XIX is 11.08 which is comparable to 2019 of 11.30

BHF Page 1 - Address on the IPCR doesn't agree with cost report; cost report agrees with Medicare report so left as is

BHF Page 3 - Reclassed blood to blood admin

BHF Page 6a & 6b - No prof fees on IPCR but on 2019; allowed for 2020

Rounding