Hospital Statement of Cost

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:** 01/01/2016	**To:** 12/31/2016	

Type of Control

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

Type of Hospital

XXXX XXXX	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)

XXXX XXXX	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 01/01/2016 and ending 12/31/2016 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	941	344,517		228,562	66.34%		47,408	6.61
2.	Psych	28	10,114		6,050	59.82%		837	7.23
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,156		19,143	79.25%			
6.	Coronary Care Unit	64	23,424		17,085	72.94%			
7.	Neonatal ICU	104	38,064		28,595	75.12%			
8.	Burn ICU	10	3,660		1,930	52.73%			
9.	UH Surg6IC	18	6,588		4,121	62.55%			
10.	UH NS 3IC								
11.	RH Ped IC	36	13,176		8,492	64.45%			
12.	Transplant ICU	8	2,928		2,649	90.47%			
13.	Peds Cancer	12	4,392		2,981	67.87%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				6,015				
22.	**Total**	**1,287**	**471,019**		**325,623**	**69.13%**		**48,245**	**6.62**
23.	Observation Bed Days				23,719				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				304			77	6.19
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				36				
6.	Coronary Care Unit				38				
7.	Neonatal ICU								
8.	Burn ICU				19				
9.	UH Surg6IC				5				
10.	UH NS 3IC								
11.	RH Ped IC				45				
12.	Transplant ICU				4				
13.	Peds Cancer				26				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**477**	**0.15%**		**77**	**6.19**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	111,317,743	887,744,132	0.125394	879,462		110,279	
2.	Recovery Room	17,902,012	134,743,888	0.132860	106,931		14,207	
3.	Delivery and Labor Room	19,833,639	66,005,744	0.300484	18,805		5,651	
4.	Anesthesiology	5,839,395	69,386,144	0.084158	74,763		6,292	
5.	Radiology - Diagnostic	82,860,625	601,411,340	0.137777	415,023		57,181	
6.	Radiology - Therapeutic	16,694,305	155,048,333	0.107672				
7.	Nuclear Medicine	3,734,428	39,631,844	0.094228	5,964		562	
8.	Laboratory	94,727,473	676,364,171	0.140054	483,478		67,713	
9.	Blood							
10.	Blood - Administration	8,708,866	91,754,677	0.094915	119,698		11,361	
11.	Intravenous Therapy							
12.	Respiratory Therapy	33,659,123	137,116,085	0.245479	276,427		67,857	
13.	Physical Therapy	24,016,326	78,082,817	0.307575	67,274		20,692	
14.	Occupational Therapy	4,111,430	16,037,929	0.256357	25,771		6,607	
15.	Speech Pathology	6,927,714	20,846,732	0.332317	7,490		2,489	
16.	EKG	7,331,125	108,873,454	0.067336	67,544		4,548	
17.	EEG	10,101,588	46,208,379	0.218609	70,310		15,370	
18.	Med. / Surg. Supplies	72,289,256	216,145,303	0.334447	139,577		46,681	
19.	Drugs Charged to Patients	242,581,463	###########	0.208591	979,929		204,404	
20.	Renal Dialysis	13,521,514	53,376,062	0.253325	48,863		12,378	
21.	Ambulance	31,807,333	108,014,616	0.294472				
22.	Endoscopy (50.01)	4,561,831	28,310,871	0.161134	44,937		7,241	
23.	Pulmonary Function(53.01)	6,105,055	37,941,187	0.160908	12,220		1,966	
24.	Cardiac Cath 59.00	4,316,678	62,916,225	0.068610				
25.	TXPLT Immun	4,017,022	11,608,327	0.346047	7,312		2,530	
26.	BMT LAB							
27.	Implmt Dev Charged	140,120,283	522,514,123	0.268166	176,913		47,442	
28.	OP RTL Pharm	122,013,454	123,271,277	0.989796				
29.	RN NBN ECMO	1,292,388	3,066,595	0.421441				
30.	CARDIOLOGY	5,024,577	48,769,912	0.103026	11,395		1,174	
31.	PSYCH OTH	2,732,238	4,948,656	0.552117				
32.	Cardiac Cath 76.03	14,329,745	162,734,411	0.088056	130,923		11,529	
33.	Day Surgery	7,374,344	4,549,834	1.620794				
34.	ECMO - ADULT	1,221,689	3,647,476	0.334941				
35.	Card Rehabilitation	1,288,709	2,963,871	0.434806				
36.	FQHC	6,622,443	5,368,033	1.233681				
37.	Home Dialysis	3,448,295	19,510,184	0.176743				
38.	HHA	58,400,289	124,638,053	0.468559				
39.	Organ ACQ	37,672,547	110,881,133	0.339756	259,422		88,140	
40.	Other ACQ CST	5,545,937						
41.	Hospice	9,191,447	19,525,264	0.470746				
42.								
	Outpatient Service Cost Centers							
43.	Clinic	72,852,553	206,828,169	0.352237	11,981		4,220	
44.	Emergency	48,536,171	561,470,427	0.086445	309,543		26,758	
45.	Observation	23,982,992	62,579,598	0.383240	20,498		7,856	
46.	**Total**				**4,772,453**		**853,128**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	255,088,480	7,658,942		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	252,281	6,050		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,011.13	1,265.94		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	304			
3.	Program general inpatient routine cost (Line 1c X Line 2)	307,384			
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)	307,384			

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	28,424,766	19,143	1,484.86	36	53,455
9.	Coronary Care Unit	29,742,543	17,085	1,740.86	38	66,153
10.	Neonatal ICU	35,852,210	28,595	1,253.79		
11.	Burn ICU	4,217,769	1,930	2,185.37	19	41,522
12.	UH Surg6IC	6,853,867	4,121	1,663.16	5	8,316
13.	UH NS 3IC					
14.	RH Ped IC	16,724,739	8,492	1,969.47	45	88,626
15.	Transplant ICU	5,653,641	2,649	2,134.25	4	8,537
16.	Peds Cancer	5,386,394	2,981	1,806.91	26	46,980
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,822,567	6,015	635.51		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					853,128
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,474,101**

Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
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							
32.	Cardiac Cath 76.03							
33.	Day Surgery							
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 Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**							

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU							
54.	Burn ICU							
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC							
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)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	1,474,101	
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)		
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)	61,250	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,535,351**	
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)	4,772,453	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	884,363	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	226,857	
	F. Coronary Care Unit	176,094	
	G. Neonatal ICU		
	H. Burn ICU	55,765	
	I. UH Surg6IC	21,740	
	J. UH NS 3IC		
	K. RH Ped IC	317,949	
	L. Transplant ICU	16,305	
	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)**	6,471,526	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		4,936,175
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	1,535,351	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,535,351	
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)**	**1,535,351**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	4,936,175
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
15-0056	**9024**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

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: 01/01/2016 To: 12/31/2016

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	6,612,023	887,744,132	0.007448	879,462		6,550	
2.	Recovery Room	170,990	134,743,888	0.001269	106,931		136	
3.	Delivery and Labor Room	466,758	66,005,744	0.007071	18,805		133	
4.	Anesthesiology	5,784,798	69,386,144	0.083371	74,763		6,233	
5.	Radiology - Diagnostic	4,412,251	601,411,340	0.007336	415,023		3,045	
6.	Radiology - Therapeutic	154,816	155,048,333	0.000999				
7.	Nuclear Medicine							
8.	Laboratory	2,240,209	676,364,171	0.003312	483,478		1,601	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	738,264	108,873,454	0.006781	67,544		458	
17.	EEG	6,060,924	46,208,379	0.131165	70,310		9,222	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	210,272	53,376,062	0.003939	48,863		192	
21.	Ambulance							
22.	Endoscopy (50.01)	135,175	28,310,871	0.004775	44,937		215	
23.	Pulmonary Function(53.01)	92,427	37,941,187	0.002436	12,220		30	
24.	Cardiac Cath 59.00	106,291	62,916,225	0.001689				
25.	TXPLT Immun							
26.	BMT LAB							
27.	Implmt Dev Charged							
28.	OP RTL Pharm							
29.	RN NBN ECMO							
30.	CARDIOLOGY	724,399	48,769,912	0.014853	11,395		169	
31.	PSYCH OTH							
32.	Cardiac Cath 76.03							
33.	Day Surgery	167,524	4,549,834	0.036820				
34.	ECMO - ADULT							
35.	Card Rehabilitation							
36.	FQHC	390,506	5,368,033	0.072747				
37.	Home Dialysis							
38.	HHA							
39.	Organ ACQ							
40.	Other ACQ CST							
41.	Hospice							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	9,942,877	206,828,169	0.048073	11,981		576	
44.	Emergency	4,528,941	561,470,427	0.008066	309,543		2,497	
45.	Observation							
46.	**Ancillary Total**						**31,057**	

* 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:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	19,623,479	252,281	77.78	304		23,645	
48.	Psych	153,661	6,050	25.40				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,050,732	19,143	107.13	36		3,857	
52.	Coronary Care Unit	57,767	17,085	3.38	38		128	
53.	Neonatal ICU	517,593	28,595	18.10				
54.	Burn ICU	43,903	1,930	22.75	19		432	
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	359,311	8,492	42.31	45		1,904	
58.	Transplant ICU	150,195	2,649	56.70	4		227	
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	67,009	6,015	11.14				
67.	**Routine Total (lines 47-66)**						**30,193**	
68.	**Ancillary Total (from line 46)**						**31,057**	
69.	**Total (Lines 67-68)**						**61,250**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	477		477
Newborn Days			
Total Inpatient Revenue	6,471,526		6,471,526
Ancillary Revenue	4,772,453		4,772,453
Routine Revenue	1,699,073		1,699,073
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Part II, Combined Adults & Peds with Psych days.

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 7 - Included Psych charges with Adults & Peds.

BHF Page 7 - Included Peds Cancer charges with Riley Hospital - RH PEDS ICU.