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: 01/01/2018	To: 12/31/2018

Type of Control

Voluntary Nonprofit
- [ ] Church
- [XXXX] Corporation
- [ ] Other (Specify) ______

Proprietary
- [ ] Individual
- [ ] Partnership
- [ ] Corporation

Government (Non-Federal)
- [ ] State
- [ ] City
- [ ] County
- [ ] Township
- [ ] Hospital District
- [ ] Other (Specify) ______

Type of Hospital

- [XXXX] General Short-Term
- [ ] General Long-Term
- [ ] Psychiatric
- [ ] Rehabilitation
- [ ] Cancer
- [ ] Other (Specify) ______

Health Care Program

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

- [XXXX] Medicaid Hospital
- [ ] Medicaid Sub I Psych
- [ ] Medicaid Sub II Rehab
- [ ] 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 01/01/2018 and ending 12/31/2018 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):

Name (Typewritten)
Title
Date
Firm
Telephone Number
Email Address

Signed (Officer or Administrator of Provider(s)):

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
15-0056	9024	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 01/01/2018	To: 12/31/2018

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	914	333,508		232,109	69.60%		50,673	6.26
2.	Psych	26	9,490		6,284	66.22%		780	8.06
3.	Rehab	10	3,650		2,050	56.16%		135	15.19
4.	Other (Sub)								
5.	Intensive Care Unit	66	24,090		18,071	75.01%			
6.	Coronary Care Unit	64	23,360		16,998	72.77%			
7.	Neonatal ICU	98	35,770		28,622	80.02%			
8.	Burn ICU	10	3,650		2,228	61.04%			
9.	UH Surg6IC	18	6,570		4,111	62.57%			
10.	UH NS 3IC								
11.	RH Ped IC	36	13,140		9,785	74.47%			
12.	Transplant ICU	8	2,920		2,237	76.61%			
13.	Peds Cancer	12	4,380		3,237	73.90%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				5,324				
22.	**Total**	**1,262**	**460,528**		**331,056**	**71.89%**		**51,588**	**6.31**
23.	Observation Bed Days				14,386				

Line No.	**Part II-Program**	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				464			150	4.63
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				42				
6.	Coronary Care Unit				76				
7.	Neonatal ICU				50				
8.	Burn ICU				2				
9.	UH Surg6IC				2				
10.	UH NS 3IC								
11.	RH Ped IC				35				
12.	Transplant ICU				1				
13.	Peds Cancer				23				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**695**	**0.21%**		**150**	**4.63**

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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	122,389,483	###########	0.118649	1,312,190		155,690	
2.	Recovery Room	19,233,375	158,213,851	0.121566	92,170		11,205	
3.	Delivery and Labor Room	14,518,351	60,730,464	0.239062	65,268		15,603	
4.	Anesthesiology	8,655,327	79,087,846	0.109439	110,802		12,126	
5.	Radiology - Diagnostic	85,667,098	579,694,378	0.147780	562,645		83,148	
6.	Radiology - Therapeutic	15,687,543	181,872,524	0.086256				
7.	Nuclear Medicine	4,197,065	48,249,499	0.086987	10,463		910	
8.	Laboratory	103,186,958	517,602,732	0.199356	521,321		103,928	
9.	Blood							
10.	Blood - Administration	13,654,224	99,154,981	0.137706	229,160		31,557	
11.	Intravenous Therapy							
12.	Respiratory Therapy	37,218,653	153,970,325	0.241726	401,567		97,069	
13.	Physical Therapy	29,803,782	91,762,027	0.324794	96,321		31,284	
14.	Occupational Therapy	5,577,910	22,547,441	0.247386	15,589		3,857	
15.	Speech Pathology	7,891,012	25,360,799	0.311150	24,570		7,645	
16.	EKG	7,016,700	90,037,776	0.077931	172,720		13,460	
17.	EEG	11,032,613	54,365,509	0.202934	47,510		9,641	
18.	Med. / Surg. Supplies	84,560,135	304,338,744	0.277849	439,971		122,246	
19.	Drugs Charged to Patients	312,346,647	###########	0.215450	1,099,533		236,894	
20.	Renal Dialysis	9,066,200	33,041,433	0.274389	61,992		17,010	
21.	Ambulance	36,814,065	161,934,892	0.227339				
22.	Endoscopy (50.01)	4,003,806	31,728,730	0.126189	23,000		2,902	
23.	Pulmonary Function(53.01)	6,489,306	40,031,673	0.162104	37,021		6,001	
24.	Cardiac Cath 59.00	4,019,134	42,942,128	0.093594				
25.	TXPLT Immun	3,318,362	8,416,606	0.394264	1,510		595	
26.	BMT LAB							
27.	Implmt Dev Charged	144,555,992	553,514,514	0.261160	293,538		76,660	
28.	OP RTL Pharm	142,897,477	160,243,412	0.891753				
29.	RN NBN ECMO	2,279,228	7,231,255	0.315191				
30.	CARDIOLOGY	3,425,053	59,216,663	0.057839	85,398		4,939	
31.	PSYCH OTH	1,709,106	6,589,855	0.259354				
32.	Cardiac Cath 76.03	13,481,313	158,165,252	0.085236	143,206		12,206	
33.	Day Surgery	8,850,129	5,809,043	1.523509				
34.	ECMO - ADULT	1,758,830	5,397,786	0.325843				
35.	Card Rehabilitation	1,306,902	3,409,612	0.383299				
36.	FQHC							
37.	Home Dialysis							
38.	HHA	82,864,618	178,650,004	0.463838				
39.	Organ ACQ	37,558,780	55,771,777	0.673437				
40.	Other ACQ CST	6,866,219						
41.	Hospice							
42.								
	Outpatient Service Cost Centers							
43.	Clinic	69,592,524	229,292,255	0.303510	28,370		8,611	
44.	Emergency	57,137,304	643,802,831	0.088750	242,643		21,535	
45.	Observation	15,887,611	70,486,971	0.225398				
46.	**Total**				**6,118,478**		**1,086,722**	

* 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:	01/01/2018	To:	12/31/2018

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)	272,222,946	8,818,896	3,446,824	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	246,495	6,284	2,050	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,104.38	1,403.39	1,681.38	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	464			
3.	Program general inpatient routine cost (Line 1c X Line 2)	512,432			
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)	512,432			

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	28,349,083	18,071	1,568.76	42	65,888
9.	Coronary Care Unit	29,655,296	16,998	1,744.63	76	132,592
10.	Neonatal ICU	39,546,497	28,622	1,381.68	50	69,084
11.	Burn ICU	4,359,855	2,228	1,956.85	2	3,914
12.	UH Surg6IC	7,547,621	4,111	1,835.96	2	3,672
13.	UH NS 3IC					
14.	RH Ped IC	19,766,655	9,785	2,020.10	35	70,704
15.	Transplant ICU	4,477,257	2,237	2,001.46	1	2,001
16.	Peds Cancer	5,164,378	3,237	1,595.42	23	36,695
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,850,452	5,324	535.40		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,086,722
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,983,704**

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: 01/01/2018 To: 12/31/2018

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)	
						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: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	7,930,076	###########	0.007688	1,312,190		10,088	
2.	Recovery Room							
3.	Delivery and Labor Room	817,715	60,730,464	0.013465	65,268		879	
4.	Anesthesiology	14,256,331	79,087,846	0.180259	110,802		19,973	
5.	Radiology - Diagnostic	3,634,386	579,694,378	0.006269	562,645		3,527	
6.	Radiology - Therapeutic	3,043,232	181,872,524	0.016733				
7.	Nuclear Medicine	208,871	48,249,499	0.004329	10,463		45	
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,512,868	90,037,776	0.027909	172,720		4,820	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	84,490	161,934,892	0.000522				
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	22,192	59,216,663	0.000375	85,398		32	
31.	PSYCH OTH	1,064,479	6,589,855	0.161533				
32.	Cardiac Cath 76.03	2,061,944	158,165,252	0.013037	143,206		1,867	
33.	Day Surgery							
34.	ECMO - ADULT							
35.	Card Rehabilitation							
36.	FQHC							
37.	Home Dialysis							
38.	HHA							
39.	Organ ACQ	2,319,829	55,771,777	0.041595				
40.	Other ACQ CST	1,246,981		#DIV/0!				
41.	Hospice							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	5,320,099	229,292,255	0.023202	28,370		658	
44.	Emergency	12,308,935	643,802,831	0.019119	242,643		4,639	
45.	Observation							
46.	**Ancillary Total**						**46,528**	

* 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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	29,643,111	246,495	120.26	464		55,801	
48.	Psych	719,800	6,284	114.54				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	503,654	16,998	29.63	76		2,252	
53.	Neonatal ICU							
54.	Burn ICU							
55.	UH Surg6IC							
56.	UH NS 3IC							
57.	RH Ped IC	2,530,319	9,785	258.59	35		9,051	
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)**						**67,104**	
68.	**Ancillary Total (from line 46)**						**46,528**	
69.	**Total (Lines 67-68)**						**113,632**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0056	9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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)	1,983,704	
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)	113,632	
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)	126,581	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,223,917**	
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)	6,118,478	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,666,168	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	222,567	
	F. Coronary Care Unit	479,767	
	G. Neonatal ICU	281,077	
	H. Burn ICU	5,000	
	I. UH Surg6IC	6,962	
	J. UH NS 3IC		
	K. RH Ped IC	300,762	
	L. Transplant ICU	6,600	
	M. Peds Cancer	57,500	
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	7,354	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	9,152,235	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,928,318
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: 15-0056	Medicaid Provider Number: 9024	
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018	To: 12/31/2018

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)	2,223,917	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,223,917	
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)**	**2,223,917**	

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024	
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018	To: 12/31/2018

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	6,928,318
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: 01/01/2018 To: 12/31/2018

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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	9,599,926	###########	0.009307	1,312,190		12,213	
2.	Recovery Room	434,699	158,213,851	0.002748	92,170		253	
3.	Delivery and Labor Room	350,068	60,730,464	0.005764	65,268		376	
4.	Anesthesiology	9,176,768	79,087,846	0.116033	110,802		12,857	
5.	Radiology - Diagnostic	7,882,288	579,694,378	0.013597	562,645		7,650	
6.	Radiology - Therapeutic	273,130	181,872,524	0.001502				
7.	Nuclear Medicine							
8.	Laboratory	3,812,273	517,602,732	0.007365	521,321		3,840	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	32,698	91,762,027	0.000356	96,321		34	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	546,259	90,037,776	0.006067	172,720		1,048	
17.	EEG	3,548,761	54,365,509	0.065276	47,510		3,101	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy (50.01)	63,473	31,728,730	0.002000	23,000		46	
23.	Pulmonary Function(53.01)	169,264	40,031,673	0.004228	37,021		157	
24.	Cardiac Cath 59.00	182,727	42,942,128	0.004255				
25.	TXPLT Immun							
26.	BMT LAB							
27.	Implmt Dev Charged							
28.	OP RTL Pharm							
29.	RN NBN ECMO							
30.	CARDIOLOGY	1,542,605	59,216,663	0.026050	85,398		2,225	
31.	PSYCH OTH							
32.	Cardiac Cath 76.03							
33.	Day Surgery	123,101	5,809,043	0.021191				
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	14,966,343	229,292,255	0.065272	28,370		1,852	
44.	Emergency	7,261,014	643,802,831	0.011278	242,643		2,737	
45.	Observation							
46.	**Ancillary Total**						**48,389**	

* 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: 01/01/2018 To: 12/31/2018

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	32,833,251	246,495	133.20	464		61,805	
48.	Psych	448,163	6,284	71.32				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,693,212	18,071	259.71	42		10,908	
52.	Coronary Care Unit	88,479	16,998	5.21	76		396	
53.	Neonatal ICU	1,021,350	28,622	35.68	50		1,784	
54.	Burn ICU	65,397	2,228	29.35	2		59	
55.	UH Surg6IC	96,172	4,111	23.39	2		47	
56.	UH NS 3IC							
57.	RH Ped IC	873,245	9,785	89.24	35		3,123	
58.	Transplant ICU	155,799	2,237	69.65	1		70	
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	130,795	5,324	24.57				
67.	**Routine Total (lines 47-66)**						**78,192**	
68.	**Ancillary Total (from line 46)**						**48,389**	
69.	**Total (Lines 67-68)**						**126,581**	

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: 01/01/2018 To: 12/31/2018

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	695		695
Newborn Days			
Total Inpatient Revenue	9,152,235		9,152,235
Ancillary Revenue	6,118,478		6,118,478
Routine Revenue	3,033,757		3,033,757
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.