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: 1701 N Senate Ave	**Medicaid Provider Number:** 9024
City: Indianapolis **State:** Indiana **Zip:** 46202	
Period Covered by Statement: **From:** 01/01/2023 **To:** 12/31/2023	

Type of Control

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

Type of Hospital

[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]	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 01/01/2023 and ending 12/31/2023 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: 01/01/2023 To: 12/31/2023

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	944	344,605		238,884	69.32%		46,659	7.14
2.	Psych	28	10,220		5,118	50.08%		741	6.91
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	69	25,185		19,342	76.80%			
6.	Coronary Care Unit	66	23,930		18,443	77.07%			
7.	Neonatal ICU	105	38,325		35,278	92.05%			
8.	Burn ICU	10	3,650		2,100	57.53%			
9.	UH Surg6IC	18	6,570		2,948	44.87%			
10.	UH NS 3IC								
11.	RH Ped IC	42	15,330		10,321	67.33%			
12.	Transplant ICU	8	2,920		2,418	82.81%			
13.	Peds Cancer	12	4,380		3,235	73.86%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				5,639				
22.	**Total**	**1,302**	**475,115**		**343,726**	**72.35%**		**47,400**	**7.13**
23.	Observation Bed Days				19,109				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				141			15	17.87
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				4				
6.	Coronary Care Unit				52				
7.	Neonatal ICU				42				
8.	Burn ICU								
9.	UH Surg6IC								
10.	UH NS 3IC								
11.	RH Ped IC				25				
12.	Transplant ICU				4				
13.	Peds Cancer								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**268**	**0.08%**		**15**	**17.87**

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: 01/01/2023 To: 12/31/2023

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	205,461,624	##########	0.158377	449,213		71,145	
2.	Recovery Room	23,931,593	178,521,125	0.134055	25,700		3,445	
3.	Delivery and Labor Room	21,889,336	101,306,873	0.216070				
4.	Anesthesiology	9,124,403	106,181,219	0.085932	50,898		4,374	
5.	Radiology - Diagnostic	117,334,907	803,457,668	0.146037	104,253		15,225	
6.	Radiology - Therapeutic	16,206,105	228,540,664	0.070911				
7.	Nuclear Medicine	4,958,752	108,887,960	0.045540	11,827		539	
8.	Laboratory	104,192,328	628,551,342	0.165766	213,689		35,422	
9.	Blood							
10.	Blood - Administration	27,539,957	220,255,884	0.125036	69,837		8,732	
11.	Intravenous Therapy							
12.	Respiratory Therapy	56,668,180	196,011,753	0.289106	285,072		82,416	
13.	Physical Therapy	49,693,466	128,743,990	0.385987	41,403		15,981	
14.	Occupational Therapy	7,939,973	26,983,343	0.294255	22,704		6,681	
15.	Speech Pathology	8,885,211	31,401,581	0.282954	12,084		3,419	
16.	EKG	8,465,540	129,302,163	0.065471	38,746		2,537	
17.	EEG	13,249,285	97,740,684	0.135555	26,272		3,561	
18.	Med. / Surg. Supplies	103,061,052	482,124,870	0.213764	44,887		9,595	
19.	Drugs Charged to Patients	510,816,029	##########	0.249014	1,019,952		253,982	
20.	Renal Dialysis	12,592,249	45,280,617	0.278094				
21.	Ambulance	75,818,352	483,730,512	0.156737				
22.	Endoscopy (50.01)	14,676,182	113,273,609	0.129564	14,788		1,916	
23.	Pulmonary Function(53.01)	5,350,559	32,568,545	0.164286				
24.	Cardiac Cath 59.00	1,448,118	4,164,962	0.347691				
25.	Transplant Immunology	4,102,677	23,960,769	0.171225	4,857		832	
26.	BMT Lab							
27.	Implants Dev Charged	114,447,244	839,526,757	0.136324	555,985		75,794	
28.	OP Retail Pharmacy	454,248,052	480,968,477	0.944445				
29.	RN NBN ECMO	3,019,706	8,736,536	0.345641				
30.	Cardiology	6,040,373	76,352,239	0.079112				
31.	Psych Services	5,940,876	916	##########				
32.	Cardiac Cath 76.03	25,248,620	231,983,942	0.108838				
33.	Day Surgery	9,750,708	30,227,223	0.322580				
34.	ECMO - Adult	3,051,923	9,298,913	0.328202				
35.	Cardiac Rehabilitation	2,097,758	7,975,367	0.263030				
36.	Allogenic Stem Cell	4,306,346	10,005,859	0.430382				
37.	Car T-Cell	33,568,899	40,693,837	0.824914				
38.	HHA	86,670,849	406,159,960	0.213391				
39.	Organ Acquisition	53,770,521	73,394,938	0.732619	120,789		88,492	
40.	Other Acquisition Exp	7,700,263						
41.	Hospice	27,376,378	49,285,399	0.555466				
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	86,789,825	305,924,971	0.283696				
44.	Emergency	74,399,536	836,780,511	0.088912	61,283		5,449	
45.	Observation	27,750,090	140,516,543	0.197486				
46.	**Total**				**3,174,239**		**689,537**	

* 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: 01/01/2023 To: 12/31/2023

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)	374,656,410	7,541,664		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	257,993	5,118		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,452.20	1,473.56		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	141			
3.	Program general inpatient routine cost (Line 1c X Line 2)	204,760			
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)	204,760			

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	39,503,793	19,342	2,042.38	4	8,170
9.	Coronary Care Unit	44,857,327	18,443	2,432.21	52	126,475
10.	Neonatal ICU	55,973,304	35,278	1,586.63	42	66,638
11.	Burn ICU	5,088,450	2,100	2,423.07		
12.	UH Surg6IC	7,906,403	2,948	2,681.95		
13.	UH NS 3IC					
14.	RH Ped IC	23,553,520	10,321	2,282.10	25	57,053
15.	Transplant ICU	6,241,713	2,418	2,581.35	4	10,325
16.	Peds Cancer	6,875,420	3,235	2,125.32		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,835,576	5,639	680.19		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					689,537
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,162,958**

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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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.	Transplant Immunology							
26.	BMT Lab							
27.	Implants Dev Charged							
28.	OP Retail Pharmacy							
29.	RN NBN ECMO							
30.	Cardiology							
31.	Psych Services							
32.	Cardiac Cath 76.03							
33.	Day Surgery							
34.	ECMO - Adult							
35.	Cardiac Rehabilitation							
36.	Allogenic Stem Cell							
37.	Car T-Cell							
38.	HHA							
39.	Organ Acquisition							
40.	Other Acquisition Exp							
41.	Hospice							
42.	Other							
	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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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)	1,162,958	
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)	60,215	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,223,173**	
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)	3,174,239	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	578,334	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	17,052	
	F. Coronary Care Unit	420,316	
	G. Neonatal ICU	281,248	
	H. Burn ICU		
	I. UH Surg6IC		
	J. UH NS 3IC		
	K. RH Ped IC	202,075	
	L. Transplant ICU	24,692	
	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)**	4,697,956	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,474,783
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: 01/01/2023 To: 12/31/2023

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)	1,223,173	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,223,173	
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)**	**1,223,173**	

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: 01/01/2023 To: 12/31/2023

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)	3,474,783
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		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 **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: 01/01/2023 To: 12/31/2023

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: 01/01/2023 To: 12/31/2023

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	10,138,286	##########	0.007815	449,213		3,511	
2.	Recovery Room	421,708	178,521,125	0.002362	25,700		61	
3.	Delivery and Labor Room							
4.	Anesthesiology	9,498,155	106,181,219	0.089452	50,898		4,553	
5.	Radiology - Diagnostic	6,498,624	803,457,668	0.008088	104,253		843	
6.	Radiology - Therapeutic	871,529	228,540,664	0.003813				
7.	Nuclear Medicine							
8.	Laboratory	4,675,549	628,551,342	0.007439	213,689		1,590	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	36,764	196,011,753	0.000188	285,072		54	
13.	Physical Therapy	82,179	128,743,990	0.000638	41,403		26	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,399,205	129,302,163	0.010821	38,746		419	
17.	EEG	2,391,840	97,740,684	0.024471	26,272		643	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	471,448	45,280,617	0.010412				
21.	Ambulance							
22.	Endoscopy (50.01)							
23.	Pulmonary Function(53.01)	588,228	32,568,545	0.018061				
24.	Cardiac Cath 59.00	211,935	4,164,962	0.050885				
25.	Transplant Immunology							
26.	BMT Lab							
27.	Implants Dev Charged							
28.	OP Retail Pharmacy							
29.	RN NBN ECMO							
30.	Cardiology	2,104,213	76,352,239	0.027559				
31.	Psych Services							
32.	Cardiac Cath 76.03							
33.	Day Surgery							
34.	ECMO - Adult							
35.	Cardiac Rehabilitation							
36.	Allogenic Stem Cell							
37.	Car T-Cell							
38.	HHA							
39.	Organ Acquisition	170,845	73,394,938	0.002328	120,789		281	
40.	Other Acquisition Exp							
41.	Hospice							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	5,637,906	305,924,971	0.018429				
44.	Emergency	13,090,240	836,780,511	0.015644	61,283		959	
45.	Observation							
46.	**Ancillary Total**						**12,940**	

* 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: 01/01/2023 To: 12/31/2023

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	64,183,910	257,993	248.78	141		35,078	
48.	Psych	352,505	5,118	68.88				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,863,696	19,342	251.46	4		1,006	
52.	Coronary Care Unit	1,511,660	18,443	81.96	52		4,262	
53.	Neonatal ICU	2,076,099	35,278	58.85	42		2,472	
54.	Burn ICU							
55.	UH Surg6IC	214,098	2,948	72.62				
56.	UH NS 3IC							
57.	RH Ped IC	1,732,246	10,321	167.84	25		4,196	
58.	Transplant ICU	157,870	2,418	65.29	4		261	
59.	Peds Cancer							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**47,275**	
68.	**Ancillary Total (from line 46)**						**12,940**	
69.	**Total (Lines 67-68)**						**60,215**	

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: 01/01/2023 To: 12/31/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	268		268
Newborn Days			
Total Inpatient Revenue	4,697,955	1	4,697,956
Ancillary Revenue	3,174,238	1	3,174,239
Routine Revenue	1,523,717		1,523,717
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 3 - Reclassed Blood costs/charges to Blood Admin costs/charges
BHF Page 3 - Clinic line includes Medicare line numbers 90.00 - 90.24
BHF Page 3 - Organ Acq line includes Medicare line numbers 105.00-110.00
BHF Page 6a & 6b - Adjusted out the professional fees as none on the IPCR
BHF Supplemental 2a & 2b - Adjusted out the OP Care Adults, Infusion & IUMG GME costs as no associated costs/charges on the cost report

Adjusted out the O/P data as only governmental hospitals need report

Minor rounding adjustment