

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: Clarian Health Partners, Inc.		Medicare Provider Number: 15-0056	
Street: I-65 at 21st Street		Medicaid Provider Number: 9024	
City: Indianapolis	State: Indiana	Zip: 46202	
Period Covered by Statement:	From: 01/01/08	To: 12/31/08	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation XXXX XXXX	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term XXXX XXXX	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital XXXX XXXX	<input type="checkbox"/> Medicaid Sub II _____	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I _____	<input type="checkbox"/> Medicaid Sub III _____	<input type="checkbox"/> 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)) Clarian Health Partners, Inc. 9024 for the cost report beginning 01/01/08 and ending 12/31/08 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 _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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	1,141	417,606		258,620	61.93%		53,163	6.06
2.	Behavioral Care Center	45	16,470		6,959	42.25%		1,012	6.88
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	61	22,326		20,001	89.59%			
6.	Coronary Care Unit	83	30,378		13,331	43.88%			
7.	Newborn ICU	35	12,810		9,481	74.01%			
8.	Burn ICU	7	2,562		1,747	68.19%			
9.	UH Surg 6IC	18	6,588		5,650	85.76%			
10.	UH NS 3IC	9	3,294		2,248	68.25%			
11.	RH Ped IC	35	12,810		9,099	71.03%			
12.	Pediatric Cancer Center	6	2,196		1,790	81.51%			
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				8,137				
22.	Total	1,440	527,040		337,063	63.95%		54,175	6.07
23.	Observation Bed Days				16,299				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				911				
2.	Behavioral Care Center								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				11				
6.	Coronary Care Unit				11				
7.	Newborn ICU				82				
8.	Burn ICU				87				
9.	UH Surg 6IC				12				
10.	UH NS 3IC				3				
11.	RH Ped IC				67				
12.	Pediatric Cancer Center				2				
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				21				
22.	Total				1,207	0.36%			

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: 01/01/08 To: 12/31/08

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	173,236,967	560,747,571	0.308939	1,135,774		350,885	
2.	Recovery Room	14,919,947	41,351,534	0.360808	68,597		24,750	
3.	Delivery and Labor Room	17,002,251	40,712,256	0.417620	35,235		14,715	
4.	Anesthesiology	16,113,335	27,992,175	0.575637	63,800		36,726	
5.	Radiology - Diagnostic	95,654,683	466,663,638	0.204976	511,214		104,787	
6.	Radiology - Therapeutic	16,691,500	59,158,502	0.282149	10,066		2,840	
7.	Nuclear Medicine	7,619,216	19,500,925	0.390710	2,810		1,098	
8.	Laboratory	83,511,282	480,598,354	0.173765	854,540		148,489	
9.	Blood							
10.	Blood - Administration	38,616,680	56,265,582	0.686329	115,136		79,021	
11.	Intravenous Therapy							
12.	Respiratory Therapy	36,915,905	143,865,689	0.256600	485,229		124,510	
13.	Physical Therapy	11,000,438	27,279,900	0.403243	51,850		20,908	
14.	Occupational Therapy	3,850,975	8,304,183	0.463739	31,923		14,804	
15.	Speech Pathology	7,245,956	13,712,166	0.528433	3,925		2,074	
16.	EKG	6,555,657	47,270,759	0.138683	9,364		1,299	
17.	EEG	4,988,712	14,659,027	0.340317	6,824		2,322	
18.	Med. / Surg. Supplies	1,692,679	12,291,988	0.137706				
19.	Drugs Charged to Patients	71,402,847	334,775,319	0.213286				
20.	Renal Dialysis	24,498,912	52,108,452	0.470152	123,118		57,884	
21.	Ambulance	18,180,185	31,804,353	0.571626				
22.	Endoscopy Unit	3,848,003	13,004,212	0.295904	7,781		2,302	
23.	Pulmonary Function	5,869,865	16,852,683	0.348304	13,070		4,552	
24.	Transplant Immunology	4,578,143	14,462,147	0.316560	4,988		1,579	
25.	Bone Marrow Trans Lab	3,584,514	6,478,045	0.553333				
26.	OP Retail Pharm	37,587,525	26,557,709	1.415315				
27.	RH NBN ECMO IC	1,323,929	1,646,313	0.804178				
28.	Cardiology	21,987,295	85,036,574	0.258563	99,607		25,755	
29.	Psych Other Ancillary	575,045	868,828	0.661863				
30.	Cardiac Catheterization	20,122,266	85,467,940	0.235436				
31.	Day Surgery	9,653,528	5,425,713	1.779218	5,207		9,264	
32.	Oncology	1,130,280	70,842	15.954942				
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Par	24,178,417	23,937,590	1.010061				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	45,229,804	49,707,620	0.909917	4,249		3,866	
44.	Emergency	40,834,370	171,007,395	0.238787	134,047		32,009	
45.	Observation	16,195,175	18,113,648	0.894087				
46.	Total				3,778,354		1,066,439	

* 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: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Behavioral Care C	Sub II	Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	273,168,447	7,747,647		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	274,919	6,959		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	993.63	1,113.33		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	911			
3.	Program general inpatient routine cost (Line 1c X Line 2)	905,197			
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)	905,197			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	29,403,467	20,001	1,470.10	11	16,171
9.	Coronary Care Unit	23,644,110	13,331	1,773.62	11	19,510
10.	Newborn ICU	9,308,132	9,481	981.77	82	80,505
11.	Burn ICU	2,797,534	1,747	1,601.34	87	139,317
12.	UH Surg 6IC	12,411,771	5,650	2,196.77	12	26,361
13.	UH NS 3IC	4,101,047	2,248	1,824.31	3	5,473
14.	RH Ped IC	17,177,588	9,099	1,887.85	67	126,486
15.	Pediatric Cancer Center	2,417,652	1,790	1,350.64	2	2,701
16.	Other					
17.	Other					
18.	Other	21,116,832				
19.	Other	1,841,488				
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	8,088,070	8,137	993.99	21	20,874
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,066,439
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,409,034

**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: 01/01/08 To: 12/31/08

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Behavioral Care Center						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Newborn ICU						
9.	Burn ICU						
10.	UH Surg 6IC						
11.	UH NS 3IC						
12.	RH Ped IC						
13.	Pediatric Cancer Center						
14.	Other						
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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
		(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:	15-0056	Medicaid Provider Number:	9024
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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	1,072,593	560,747,571	0.001913	1,135,774		2,173	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,445,538	27,992,175	0.230262	63,800		14,691	
5.	Radiology - Diagnostic	97	466,663,638		511,214			
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,084,572	480,598,354	0.004337	854,540		3,706	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	729,927	47,270,759	0.015441	9,364		145	
17.	EEG	33,283	14,659,027	0.002270	6,824		15	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	201,250	52,108,452	0.003862	123,118		475	
21.	Ambulance							
22.	Endoscopy Unit							
23.	Pulmonary Function							
24.	Transplant Immunology							
25.	Bone Marrow Trans Lab							
26.	OP Retail Pharm							
27.	RH NBN ECMO IC							
28.	Cardiology							
29.	Psych Other Ancillary							
30.	Cardiac Catheterization	2,372,963	85,467,940	0.027764				
31.	Day Surgery							
32.	Oncology							
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Pand	586,095	23,937,590	0.024484				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	2,468,777	49,707,620	0.049666	4,249		211	
44.	Emergency	185	171,007,395	0.000001	134,047			
45.	Observation							
46.	Ancillary Total						21,416	

* 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: 01/01/08 To: 12/31/08

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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	2,241,354	274,919	8.15	911		7,425	
48.	Behavioral Care Center	124,978	6,959	17.96				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Newborn ICU	227,628	9,481	24.01	82		1,969	
54.	Burn ICU	8,750	1,747	5.01	87		436	
55.	UH Surg 6IC							
56.	UH NS 3IC							
57.	RH Ped IC	389,926	9,099	42.85	67		2,871	
58.	Pediatric Cancer Center	35,000	1,790	19.55	2		39	
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	26,250	8,137	3.23	21		68	
67.	Routine Total (lines 47-66)						12,808	
68.	Ancillary Total (from line 46)						21,416	
69.	Total (Lines 67-68)						34,224	

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

PRELIMINARY

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	2,409,034	
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)	34,224	
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)	81,898	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,525,156	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	3,778,354	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,591,149	
	B. Behavioral Care Center		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	35,433	
	F. Coronary Care Unit	35,225	
	G. Newborn ICU	202,456	
	H. Burn ICU	308,054	
	I. UH Surg 6IC	37,601	
	J. UH NS 3IC	10,838	
	K. RH Ped IC	240,259	
	L. Pediatric Cancer Center	6,160	
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	47,140	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	6,292,669	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,767,513
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: 01/01/08 To: 12/31/08

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	2,525,156	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,525,156	
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	2,525,156	

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

PRELIMINARY

Medicare Provider Number: 15-0056	Medicaid Provider Number: 9024
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	3,767,513
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 01/01/08 To: 12/31/08

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Behavioral Care	Sub II	Sub III
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 Behavioral Care	Sub II	Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. 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 Behavioral Care	Sub II	Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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 1)				

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: 01/01/08 To: 12/31/08

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	6,610,519	560,747,571	0.011789	1,135,774		13,390	
2.	Recovery Room							
3.	Delivery and Labor Room	1,077,229	40,712,256	0.026460	35,235		932	
4.	Anesthesiology	4,145,425	27,992,175	0.148092	63,800		9,448	
5.	Radiology - Diagnostic	4,155,417	466,663,638	0.008905	511,214		4,552	
6.	Radiology - Therapeutic	481,392	59,158,502	0.008137	10,066		82	
7.	Nuclear Medicine	462,319	19,500,925	0.023708	2,810		67	
8.	Laboratory	2,238,929	480,598,354	0.004659	854,540		3,981	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	74,480	143,865,689	0.000518	485,229		251	
13.	Physical Therapy	415,087	27,279,900	0.015216	51,850		789	
14.	Occupational Therapy							
15.	Speech Pathology	728,447	13,712,166	0.053124	3,925		209	
16.	EKG	327,892	47,270,759	0.006936	9,364		65	
17.	EEG	565,864	14,659,027	0.038602	6,824		263	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	542,248	52,108,452	0.010406	123,118		1,281	
21.	Ambulance							
22.	Endoscopy Unit	7,267	13,004,212	0.000559	7,781		4	
23.	Pulmonary Function	794,752	16,852,683	0.047159	13,070		616	
24.	Transplant Immunology							
25.	Bone Marrow Trans Lab							
26.	OP Retail Pharm							
27.	RH NBN ECMO IC							
28.	Cardiology	1,285,228	85,036,574	0.015114	99,607		1,505	
29.	Psych Other Ancillary	84,470	868,828	0.097223				
30.	Cardiac Catheterization	399,647	85,467,940	0.004676				
31.	Day Surgery							
32.	Oncology	236,155	70,842	3.333545				
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Pa							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic	9,996,616	49,707,620	0.201108	4,249		855	
44.	Emergency	2,901,980	171,007,395	0.016970	134,047		2,275	
45.	Observation							
46.	Ancillary Total						40,565	

* 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: 01/01/08 To: 12/31/08

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	8,881,241	274,919	32.30	911		29,425	
48.	Behavioral Care Center	376,939	6,959	54.17				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	2,265,270	20,001	113.26	11		1,246	
52.	Coronary Care Unit	141,693	13,331	10.63	11		117	
53.	Newborn ICU	949,161	9,481	100.11	82		8,209	
54.	Burn ICU							
55.	UH Surg 6IC	643,976	5,650	113.98	12		1,368	
56.	UH NS 3IC	475,035	2,248	211.31	3		634	
57.	RH Ped IC	45,414	9,099	4.99	67		334	
58.	Pediatric Cancer Center							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						41,333	
68.	Ancillary Total (from line 46)						40,565	
69.	Total (Lines 67-68)						81,898	

