

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: 01/01/2009	To: 12/31/2009	

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 01/01/2009 and ending 12/31/2009 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: 01/01/2009 To: 12/31/2009

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	1,188	433,620		268,716	61.97%		56,086	5.95
2.	Behavioral Care Center	45	16,425		7,241	44.09%		999	7.25
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	65	23,725		19,672	82.92%			
6.	Coronary Care Unit	85	31,025		12,670	40.84%			
7.	Newborn ICU	35	12,775		9,690	75.85%			
8.	Burn ICU	7	2,555		1,578	61.76%			
9.	UH Surg 6IC	18	6,570		5,405	82.27%			
10.	UH NS 3IC	9	3,285		2,319	70.59%			
11.	RH Ped IC	35	12,775		9,235	72.29%			
12.	Transplant ICU	17	6,205		2,571	41.43%			
13.	Pediatric Cancer Center	6	2,190		1,892	86.39%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				7,449				
22.	Total	1,510	551,150		348,438	63.22%		57,085	5.97
23.	Observation Bed Days				11,617				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				842			143	7.31
2.	Behavioral Care Center								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				42				
6.	Coronary Care Unit				23				
7.	Newborn ICU								
8.	Burn ICU				24				
9.	UH Surg 6IC				19				
10.	UH NS 3IC				11				
11.	RH Ped IC				85				
12.	Transplant ICU								
13.	Pediatric Cancer Center								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				65				
22.	Total				1,111	0.32%		143	7.31

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: 01/01/2009 To: 12/31/2009

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	172,552,886	664,064,915	0.259843	1,514,868		393,628	
2.	Recovery Room	13,884,913	48,956,774	0.283616	89,855		25,484	
3.	Delivery and Labor Room							
4.	Anesthesiology	15,431,596	34,436,208	0.448121	63,280		28,357	
5.	Radiology - Diagnostic	90,397,254	497,362,674	0.181753	565,421		102,767	
6.	Radiology - Therapeutic	14,733,265	70,272,941	0.209658				
7.	Nuclear Medicine	7,889,539	22,224,205	0.354998	6,662		2,365	
8.	Laboratory	78,705,191	528,923,289	0.148803	954,578		142,044	
9.	Blood							
10.	Blood - Administration	37,891,621	55,242,227	0.685918	82,704		56,728	
11.	Intravenous Therapy							
12.	Respiratory Therapy	36,326,127	173,026,948	0.209945	715,361		150,186	
13.	Physical Therapy	10,959,672	31,026,168	0.353240	46,224		16,328	
14.	Occupational Therapy	3,857,374	9,225,428	0.418124	26,356		11,020	
15.	Speech Pathology	7,354,791	13,921,104	0.528320	7,374		3,896	
16.	EKG	6,059,845	48,646,893	0.124568	47,770		5,951	
17.	EEG	4,956,996	18,309,152	0.270739	19,409		5,255	
18.	Med. / Surg. Supplies	1,212,463	6,133,995	0.197663	24,445		4,832	
19.	Drugs Charged to Patients	80,443,076	387,986,270	0.207335	991,583		205,590	
20.	Renal Dialysis	23,218,309	58,288,626	0.398333				
21.	Ambulance	16,602,792	34,855,884	0.476327				
22.	Endoscopy Unit	3,309,741	12,616,963	0.262325	15,924		4,177	
23.	Pulmonary Function	5,561,233	20,383,520	0.272830	8,508		2,321	
24.	Transplant Immunology	4,805,346	18,676,139	0.257299	11,879		3,056	
25.	Bone Marrow Trans Lab	3,663,718	9,102,484	0.402497	21,358		8,597	
26.	OP Retail Pharm	46,130,607	34,859,927	1.323313				
27.	RH NBN ECMO IC	663,863	1,198,293	0.554007				
28.	Cardiology	20,527,311	94,966,440	0.216153	58,534		12,652	
29.	Psych Other Ancillary	1,834,038	945,762	1.939217				
30.	Cardiac Catheterization	16,415,116	78,826,553	0.208243	5,808		1,209	
31.	Day Surgery	8,257,539	7,399,872	1.115903	3,613		4,032	
32.	Oncology	7,215,842	5,104	#####				
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Par	26,034,170	25,738,640	1.011482	136,014		137,576	
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	49,584,415	75,864,853	0.653589	11,375		7,435	
44.	Emergency	39,613,903	218,051,050	0.181673	201,776		36,657	
45.	Observation	11,423,112	15,352,799	0.744041				
46.	Total				5,630,679		1,372,143	

* 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: 01/01/2009 To: 12/31/2009

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)	275,654,446	6,813,886		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	280,333	7,241		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	983.31	941.01		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	842			
3.	Program general inpatient routine cost (Line 1c X Line 2)	827,947			
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)	827,947			

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	29,196,779	19,672	1,484.18	42	62,336
9.	Coronary Care Unit	21,460,905	12,670	1,693.84	23	38,958
10.	Newborn ICU	8,759,678	9,690	903.99		
11.	Burn ICU	2,735,464	1,578	1,733.50	24	41,604
12.	UH Surg 6IC	10,807,715	5,405	1,999.58	19	37,992
13.	UH NS 3IC	3,740,928	2,319	1,613.16	11	17,745
14.	RH Ped IC	16,425,275	9,235	1,778.59	85	151,180
15.	Transplant ICU	5,136,184	2,571	1,997.74		
16.	Pediatric Cancer Center	2,435,811	1,892	1,287.43		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	7,729,540	7,449	1,037.66	65	67,448
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,372,143
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,617,353

**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: 01/01/2009 To: 12/31/2009

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.	Transplant ICU						
14.	Pediatric Cancer Center						
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: 01/01/2009 To: 12/31/2009

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	870,335	664,064,915	0.001311	1,514,868		1,986	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	6,522,863	34,436,208	0.189419	63,280		11,986	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,859,696	528,923,289	0.005407	954,578		5,161	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	758,541	48,646,893	0.015593	47,770		745	
17.	EEG	19,841	18,309,152	0.001084	19,409		21	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	154,126	58,288,626	0.002644				
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	1,331,272	78,826,553	0.016889	5,808		98	
31.	Day Surgery							
32.	Oncology							
33.	Acquis [D-6]-Kid,Heart,Liver,Lung,Pand							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	3,015,332	75,864,853	0.039746	11,375		452	
44.	Emergency							
45.	Observation							
46.	Ancillary Total						20,449	

* 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: 01/01/2009 To: 12/31/2009

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	2,286,078	280,333	8.15	842		6,862	
48.	Behavioral Care Center	164,539	7,241	22.72				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Newborn ICU	30,451	9,690	3.14				
54.	Burn ICU	6,563	1,578	4.16	24		100	
55.	UH Surg 6IC							
56.	UH NS 3IC							
57.	RH Ped IC	938,355	9,235	101.61	85		8,637	
58.	Transplant ICU							
59.	Pediatric Cancer Center	35,000	1,892	18.50				
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						15,599	
68.	Ancillary Total (from line 46)						20,449	
69.	Total (Lines 67-68)						36,048	

**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: 01/01/2009 To: 12/31/2009

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)	2,617,353	
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)	36,048	
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)	77,728	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,731,129	
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)	5,630,679	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,762,621	
	B. Behavioral Care Center		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	144,923	
	F. Coronary Care Unit	76,691	
	G. Newborn ICU		
	H. Burn ICU	86,087	
	I. UH Surg 6IC	64,902	
	J. UH NS 3IC	36,678	
	K. RH Ped IC	378,881	
	L. Transplant ICU		
	M. Pediatric Cancer Center		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	164,928	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	8,346,390	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,615,261
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: 01/01/2009 To: 12/31/2009

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)	2,731,129	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,731,129	
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)	2,731,129	

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: 01/01/2009 To: 12/31/2009

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)	5,615,261
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: 01/01/2009 To: 12/31/2009

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: 01/01/2009 To: 12/31/2009

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	7,035,519	664,064,915	0.010595	1,514,868		16,050	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	4,537,765	34,436,208	0.131773	63,280		8,339	
5.	Radiology - Diagnostic	4,650,092	497,362,674	0.009349	565,421		5,286	
6.	Radiology - Therapeutic	517,796	70,272,941	0.007368				
7.	Nuclear Medicine	484,663	22,224,205	0.021808	6,662		145	
8.	Laboratory	2,084,402	528,923,289	0.003941	954,578		3,762	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	72,735	173,026,948	0.000420	715,361		300	
13.	Physical Therapy	430,402	31,026,168	0.013872	46,224		641	
14.	Occupational Therapy							
15.	Speech Pathology	717,664	13,921,104	0.051552	7,374		380	
16.	EKG	265,560	48,646,893	0.005459	47,770		261	
17.	EEG	566,751	18,309,152	0.030955	19,409		601	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	202,014	58,288,626	0.003466				
21.	Ambulance							
22.	Endoscopy Unit	136	12,616,963	0.000011	15,924			
23.	Pulmonary Function	892,259	20,383,520	0.043774	8,508		372	
24.	Transplant Immunology							
25.	Bone Marrow Trans Lab	13,353	9,102,484	0.001467	21,358		31	
26.	OP Retail Pharm							
27.	RH NBN ECMO IC							
28.	Cardiology	1,483,502	94,966,440	0.015621	58,534		914	
29.	Psych Other Ancillary	69,379	945,762	0.073358				
30.	Cardiac Catheterization	472,138	78,826,553	0.005990	5,808		35	
31.	Day Surgery							
32.	Oncology	1,013,948	5,104	198.657524				
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	11,865,952	75,864,853	0.156409	11,375		1,779	
44.	Emergency	3,078,170	218,051,050	0.014117	201,776		2,848	
45.	Observation							
46.	Ancillary Total						41,744	

* 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: 01/01/2009 To: 12/31/2009

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	8,741,761	280,333	31.18	842		26,254	
48.	Behavioral Care Center	455,410	7,241	62.89				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,764,191	19,672	89.68	42		3,767	
52.	Coronary Care Unit	107,986	12,670	8.52	23		196	
53.	Newborn ICU	948,129	9,690	97.85				
54.	Burn ICU							
55.	UH Surg 6IC	686,832	5,405	127.07	19		2,414	
56.	UH NS 3IC	487,940	2,319	210.41	11		2,315	
57.	RH Ped IC	112,756	9,235	12.21	85		1,038	
58.	Transplant ICU							
59.	Pediatric Cancer Center							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						35,984	
68.	Ancillary Total (from line 46)						41,744	
69.	Total (Lines 67-68)						77,728	

