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: Loyola University Medical Center DBA Foster G. McGaw Hospital		**Medicare Provider Number:** 14-0276	
Street: 2160 S. First Avenue		**Medicaid Provider Number:** 13027	
City: Maywood	**State:** Illinois	**Zip:** 60153	
Period Covered by Statement:	**From:** 07/01/2009	**To:** 06/30/2010	

Type of Control

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

Type of Hospital

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

Health Care Program

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

	Medicaid Hospital	XXXX XXXX	Medicaid Sub II Rehabilitation		DHS - Office of Rehabilitation Services
	Medicaid Sub I		Medicaid Sub III		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)) Loyola University Medical Cer 13027 for the cost report beginning 07/01/2009 and ending 06/30/2010 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:	Medicaid Provider Number:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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	313	114,245		70,789	61.96%		20,181	4.60
2.									
3.	Rehab	32	11,680		8,510	72.86%		696	12.23
4.	Sub III								
5.	Intensive Care Unit	62	22,630		14,261	63.02%			
6.	Coronary Care Unit								
7.	Burn ICU	3	1,095		840	76.71%			
8.	NICU								
9.	PICU								
10.	Heart Transplant	10	3,650		3,311	90.71%			
11.	Bone ICU	11	4,015		3,612	89.96%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	25	9,125		1,410	15.45%			
22.	**Total**	**456**	**166,440**		**102,733**	**61.72%**		**20,877**	**4.85**
23.	Observation Bed Days								

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.									
3.	Rehab				881			62	14.21
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Burn ICU								
8.	NICU								
9.	PICU								
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**881**	**0.86%**		**62**	**14.21**

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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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, ASC	84,148,290	166,671,909	0.504874				
2.	Recovery Room	6,130,951	35,282,007	0.173770				
3.	Delivery and Labor Room	4,081,691	8,129,972	0.502055				
4.	Anesthesiology	8,261,827	60,469,521	0.136628	1,426		195	
5.	Radiology - Diagnostic,Ultrasound,MR	40,776,065	185,826,051	0.219431	76,866		16,867	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	5,845,195	22,534,280	0.259391	831		216	
8.	Laboratory,Surg Path,HLA	37,043,143	192,813,161	0.192119	104,743		20,123	
9.	Blood							
10.	Blood - Administration	10,398,696	20,696,682	0.502433	14,414		7,242	
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,752,815	42,233,808	0.278280	32,839		9,138	
13.	Physical Therapy	6,457,119	16,728,601	0.385993	282,417		109,011	
14.	Occupational Therapy	2,644,533	7,118,215	0.371516	267,981		99,559	
15.	Speech Pathology	899,352	2,446,401	0.367622	32,586		11,979	
16.	EKG	21,284,440	74,558,540	0.285473	12,741		3,637	
17.	EEG	2,834,812	5,885,397	0.481669	1,092		526	
18.	Med. / Surg. Supplies	10,649,670	13,378,613	0.796022	21,788		17,344	
19.	Drugs Charged to Patients	35,165,888	106,050,526	0.331596	210,983		69,961	
20.	Renal Dialysis	8,418,757	23,573,451	0.357129	9,870		3,525	
21.	Ambulance	274,664	12,210	22.495004				
22.	Cancer Center	39,472,663	82,371,497	0.479203				
23.	Loyola OP Center,Psych Social Reha	49,572,425	84,575,736	0.586131	34,983		20,505	
24.	Cardiac Cath Lab	16,531,163	52,337,380	0.315858	13,155		4,155	
25.	Gastro Services	6,216,875	19,411,406	0.320269	3,854		1,234	
26.	Pulmonary	1,161,097	1,728,907	0.671579				
27.	Hyperalimentation							
28.	Peripheral Vascular	1,520,283	6,922,190	0.219625	8,275		1,817	
29.	Clinic, Occ Hlth, Bone Marrow Proc	2,755,745	2,661,814	1.035288				
30.	OBT Medical Center	9,222,476	22,496,488	0.409952				
31.	Organ Acquistion[from W/S D-6]	8,167,542	8,104,705	1.007753				
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	35,797,303	53,781,290	0.665609				
44.	Emergency	14,980,087	58,268,791	0.257086	9		2	
45.	Observation (Non-distinct)	6,073,003	8,868,813	0.684759				
46.	**Total**				**1,130,853**		**397,036**	

* 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:			
14-0276	13027			
Program:	**Period Covered by Statement:**			
Medicaid-Rehabilitation	From:	07/01/2009	To:	06/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I	Sub II Rehab	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	66,240,798		8,410,952	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	70,789		8,510	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	935.75		988.36	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			881	
3.	Program general inpatient routine cost (Line 1c X Line 2)			870,745	
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)			870,745	

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	24,402,802	14,261	1,711.16		
9.	Coronary Care Unit					
10.	Burn ICU	1,247,478	840	1,485.09		
11.	NICU					
12.	PICU					
13.	Heart Transplant	4,780,727	3,311	1,443.89		
14.	Bone ICU	4,776,729	3,612	1,322.46		
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	640,400	1,410	454.18		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					397,036
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,267,781**

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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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.							
4.	Rehab						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	NICU						
10.	PICU						
11.	Heart Transplant						
12.	Bone ICU						
13.	Other						
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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation (Non-distinct)								
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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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, ASC							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic,Ultrasound,MRI							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory,Surg Path,HLA							
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.	Cancer Center							
23.	Loyola OP Center,Psych Social Rehab							
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Clinic, Occ Hlth, Bone Marrow Proc							
30.	OBT Medical Center							
31.	Organ Acquistion[from W/S D-6]							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation (Non-distinct)							
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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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							
48.								
49.	Rehab							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	NICU							
55.	PICU							
56.	Heart Transplant							
57.	Bone ICU							
58.	Other							
59.	Other							
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)**							

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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)	1,267,781	
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)	3,271	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,271,052**	
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)	1,130,853	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B.		
	C. Rehab	668,096	
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Burn ICU		
	H. NICU		
	I. PICU		
	J. Heart Transplant		
	K. Bone ICU		
	L. Other		
	M. Other		
	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)**	1,798,949	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		527,897
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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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)	1,271,052	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,271,052	
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)**	**1,271,052**	

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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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)	527,897
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:**
14-0276	**13027**
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	**From: 07/01/2009 To: 06/30/2010**

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**	**Sub II Rehab**	**Sub III 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**	**Sub II Rehab**	**Sub III 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**	**Sub II Rehab**	**Sub III 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:	Medicaid Provider Number:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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, ASC	3,444,221	166,671,909	0.020665				
2.	Recovery Room							
3.	Delivery and Labor Room	235,533	8,129,972	0.028971				
4.	Anesthesiology	2,300,920	60,469,521	0.038051	1,426		54	
5.	Radiology - Diagnostic,Ultrasound,M	1,531,323	185,826,051	0.008241	76,866		633	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	288,510	22,534,280	0.012803	831		11	
8.	Laboratory,Surg Path,HLA	992,245	192,813,161	0.005146	104,743		539	
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	747,788	23,573,451	0.031722	9,870		313	
21.	Ambulance							
22.	Cancer Center	25,057	82,371,497	0.000304				
23.	Loyola OP Center,Psych Social Reha	4,160,127	84,575,736	0.049188	34,983		1,721	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary	167,522	1,728,907	0.096895				
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Clinic, Occ Hlth, Bone Marrow Proc							
30.	OBT Medical Center	445,294	22,496,488	0.019794				
31.	Organ Acquistion[from W/S D-6]							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	81,613	53,781,290	0.001517				
44.	Emergency	1,280,755	58,268,791	0.021980	9			
45.	Observation (Non-distinct)							
46.	**Ancillary Total**						**3,271**	

* 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:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

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	4,705,171	70,789	66.47				
48.								
49.	Rehab							
50.	Sub III							
51.	Intensive Care Unit	1,462,708	14,261	102.57				
52.	Coronary Care Unit							
53.	Burn ICU	126,342	840	150.41				
54.	NICU							
55.	PICU							
56.	Heart Transplant	228,374	3,311	68.97				
57.	Bone ICU	639,122	3,612	176.94				
58.	Other							
59.	Other							
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)**						**3,271**	
69.	**Total (Lines 67-68)**						**3,271**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13027
Program:	**Period Covered by Statement:**
Medicaid-Rehabilitation	From: 07/01/2009 To: 06/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	881		881
Newborn Days			
Total Inpatient Revenue	1,798,949		1,798,949
Ancillary Revenue	1,130,853		1,130,853
Routine Revenue	668,096		668,096
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Reclassified blood as Blood-Admin.
Adjusted Adults & Peds and Bone ICU charges to Rehab Room & Board charges.