

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 Ronald McDonald Child Hospital		Medicare Provider Number: 14-0276
Street: 2160 S. First Avenue		Medicaid Provider Number: 13001
City: Maywood	State: Illinois	Zip: 60153
Period Covered by Statement:	From: 07/01/2018	To: 06/30/2019

Type of Control

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

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<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	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> _____
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> _____

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 13001 for the cost report beginning 07/01/2018 and ending 06/30/2019 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 _____
 Email Address _____

 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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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	34	12,410		2,845	22.93%		2,770	4.28
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	4	1,460		544	37.26%			
6.	Coronary Care Unit								
7.	Burn ICU	2	730		49	6.71%			
8.	NICU	50	18,250		6,494	35.58%			
9.	PICU	14	5,110		1,917	37.51%			
10.	Heart Transplant								
11.	Bone ICU	1	365						
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	105	38,325		11,849	30.92%		2,770	4.28
23.	Observation Bed Days				952				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,352			491	6.78
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				59				
6.	Coronary Care Unit								
7.	Burn ICU				5				
8.	NICU				706				
9.	PICU				208				
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				3,330	28.10%		491	6.78

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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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	55,019,492	194,074,677	0.283497				
2.	Recovery Room	6,578,552	72,833,176	0.090324				
3.	Delivery and Labor Room	5,262,179	14,590,841	0.360649				
4.	Anesthesiology	3,296,521	130,082,442	0.025342				
5.	Radiology - Diagnostic	27,886,218	313,028,920	0.089085				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	10,129,394	40,214,878	0.251882				
8.	Laboratory	34,687,598	441,708,138	0.078531				
9.	Blood							
10.	Blood - Administration	11,063,863	40,874,571	0.270678				
11.	Intravenous Therapy							
12.	Respiratory Therapy	12,191,003	71,171,449	0.171291				
13.	Physical Therapy	2,935,293	15,318,656	0.191616				
14.	Occupational Therapy	1,718,579	8,923,465	0.192591				
15.	Speech Pathology	749,245	3,682,055	0.203486				
16.	EKG	5,189,255	57,297,503	0.090567				
17.	EEG	2,657,201	13,055,447	0.203532				
18.	Med. / Surg. Supplies	113,894,990	155,128,642	0.734197	314,506		230,909	
19.	Drugs Charged to Patients	117,615,009	392,824,586	0.299408				
20.	Renal Dialysis	8,957,958	46,777,566	0.191501				
21.	Ambulance	655,657						
22.	Cancer Center	20,699,157	28,824,101	0.718120				
23.	Loyola OP Center, Psych Social Rehabil	53,701,407	170,374,003	0.315197				
24.	Cardiac Cath Lab	16,108,715	122,440,559	0.131564				
25.	Gastro Services	7,984,394	80,382,758	0.099330				
26.	Pulmonary	1,129,880	5,577,608	0.202574				
27.	Other							
28.	Peripheral Vascular	1,609,522	18,264,214	0.088124				
29.	Other OP Clinics							
30.	OBT Outpatient Center	13,981,305	29,544,870	0.473223				
31.	Organ Acquisition	28,226,533	55,601,956	0.507654				
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	93,093,939	215,637,311	0.431715				
44.	Emergency	17,520,414	139,981,258	0.125163				
45.	Observation	15,383,387	44,282,445	0.347392	250,847		87,142	
46.	Total				565,353		318,051	

* 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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	3,230,328			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	3,797			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	850.76			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,352			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,000,988			
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)	2,000,988			

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	861,166	544	1,583.03	59	93,399
9.	Coronary Care Unit					
10.	Burn ICU	241,990	49	4,938.57	5	24,693
11.	NICU	12,100,308	6,494	1,863.31	706	1,315,497
12.	PICU	4,098,452	1,917	2,137.95	208	444,694
13.	Heart Transplant					
14.	Bone ICU	726,058				
15.	Other					
16.	Reconcile ICUs to Filed					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					318,051
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,197,322

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**
PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	NICU						
10.	PICU						
11.	Heart Transplant						
12.	Bone ICU						
13.	Other						
14.	Reconcile ICUs to Filed						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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.	Cancer Center							
23.	Loyola OP Center, Psych Social Rehab							
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Other							
28.	Peripheral Vascular							
29.	Other OP Clinics							
30.	OBT Outpatient Center							
31.	Organ Acquisition							
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							
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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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.	Burn ICU							
54.	NICU							
55.	PICU							
56.	Heart Transplant							
57.	Bone ICU							
58.	Other							
59.	Reconcile ICUs to Filed							
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: 14-0276		Medicaid Provider Number: 13001	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2018 To: 06/30/2019	
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)	4,197,322	
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)	482,326	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	4,679,648	
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)	565,353	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	11,471,779	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	288,312	
	F. Coronary Care Unit		
	G. Burn ICU	25,799	
	H. NICU	4,281,537	
	I. PICU	1,264,999	
	J. Heart Transplant		
	K. Bone ICU		
	L. Other		
	M. Reconcile ICUs to Filed		
	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)	17,897,779	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		13,218,131
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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	4,679,648	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,679,648	
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)	4,679,648	

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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	13,218,131
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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	9,991,254	194,074,677	0.051481				
2.	Recovery Room							
3.	Delivery and Labor Room	683,251	14,590,841	0.046827				
4.	Anesthesiology	6,674,681	130,082,442	0.051311				
5.	Radiology - Diagnostic	3,985,287	313,028,920	0.012731				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,293,817	40,214,878	0.032173				
8.	Laboratory	2,878,379	441,708,138	0.006516				
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	485,960	46,777,566	0.010389				
21.	Ambulance							
22.	Cancer Center	965,689	28,824,101	0.033503				
23.	Loyola OP Center, Psych Social Reha	11,102,317	170,374,003	0.065164				
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Other							
28.	Peripheral Vascular							
29.	Other OP Clinics							
30.	OBT Outpatient Center	1,291,740	29,544,870	0.043721				
31.	Organ Acquisition							
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	236,749	215,637,311	0.001098				
44.	Emergency	3,715,309	139,981,258	0.026541				
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 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: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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	560,154	3,797	147.53	2,352		346,991	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	117,855	544	216.65	59		12,782	
52.	Coronary Care Unit							
53.	Burn ICU	43,034	49	878.24	5		4,391	
54.	NICU	409,120	6,494	63.00	706		44,478	
55.	PICU	679,098	1,917	354.25	208		73,684	
56.	Heart Transplant							
57.	Bone ICU	66,248		#DIV/0!				
58.	Other							
59.	Reconcile ICUs to Filed							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						482,326	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						482,326	

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,330		3,330
Newborn Days			
Total Inpatient Revenue	17,897,780	(1)	17,897,779
Ancillary Revenue	565,353		565,353
Routine Revenue	17,332,427	(1)	17,332,426
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Total costs and I&R costs are allocated (between Acute& Children's) for Adults & Peds, ICU, and Burn ICU. See supplemental worksheet.

Operating Room costs and charges from W/S C include Ambulatory Surgery Center.

Radiology-Diagnostic costs and charges from W/S C also include Radiology-Ultrasound, CT Scan, and MRI.

Laboratory costs and charges from W/S C include Lab Surgical Pathology and Lab-HLA.

Med Supplies costs and charges includes Implant Devices from W/S C.

Loyola O/P (90.07) costs and charges also includes Psych Social(90.03), Bone Marrow Proc, Bariatrics, Hepatology

Clinic costs and charges from W/S C includes lines 90, 90.09 through 90.34.

Organ Acquisition costs came from W/S C, Column 1, Lines 105-112.

Completed BHF Supp. No. 2 with proper amounts from W/S B, Part I, Column 25 as per instructions.

Minor \$1 adjustment due to rounding