

Hospital Statement of Cost

BHF Page 1

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: 07/01/2010	To: 06/30/2011

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☐ 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	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ 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 07/01/2010 and ending 06/30/2011 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
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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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		65,978	57.75%		20,339	4.31
2.	Psych								
3.	Rehab	32	11,680		9,561	81.86%		752	12.71
4.	Other (Sub)								
5.	Intensive Care Unit	62	22,630		14,356	63.44%			
6.	Coronary Care Unit								
7.	Burn ICU	3	1,095		804	73.42%			
8.	NICU								
9.	PICU								
10.	Heart Transplant	10	3,650		2,944	80.66%			
11.	Bone ICU	12	4,380		3,677	83.95%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,399				
22.	Total	432	157,680		98,719	62.61%		21,091	4.61
23.	Observation Bed Days				6,582				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,426			5,296	2.66
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,179				
6.	Coronary Care Unit								
7.	Burn ICU				754				
8.	NICU								
9.	PICU								
10.	Heart Transplant				349				
11.	Bone ICU				394				
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				242				
22.	Total				14,344	14.53%		5,296	2.66

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0276		13027	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 07/01/2010	To: 06/30/2011

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	78,563,123	172,436,779	0.455605	14,352,134		6,538,904	
2.	Recovery Room	5,152,089	33,634,298	0.153180	3,432,180		525,741	
3.	Delivery and Labor Room	3,395,906	7,823,319	0.434075	3,513,810		1,525,257	
4.	Anesthesiology	7,310,223	59,875,606	0.122090	7,039,596		859,464	
5.	Radiology - Diagnostic	33,816,255	185,849,778	0.181955	6,740,931		1,226,546	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	5,242,827	22,241,224	0.235726	7,349,518		1,732,472	
8.	Laboratory	35,755,829	201,636,373	0.177328	16,057,471		2,847,439	
9.	Blood							
10.	Blood - Administration	9,993,947	22,349,416	0.447168	2,921,814		1,306,542	
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,696,690	41,396,643	0.234239	14,771,760		3,460,122	
13.	Physical Therapy	6,116,348	17,426,967	0.350970	909,227		319,111	
14.	Occupational Therapy	2,474,632	8,583,218	0.288311	738,167		212,822	
15.	Speech Pathology	933,890	2,729,182	0.342187	431,136		147,529	
16.	EKG	22,054,425	86,695,206	0.254390	4,955,017		1,260,507	
17.	EEG	2,390,859	6,058,681	0.394617	584,033		230,469	
18.	Med. / Surg. Supplies	3,869,907	3,670,787	1.054244	935,471		986,215	
19.	Drugs Charged to Patients	34,317,075	104,035,675	0.329859	20,517,157		6,767,769	
20.	Renal Dialysis	4,403,655	25,054,512	0.175763	530,609		93,261	
21.	Ambulance	366,810	2,387	153.669879				
22.	Cancer Center	31,093,860	84,430,841	0.368276	239		88	
23.	Loyola OP Center, Psych Social Reha	48,061,682	91,857,025	0.523223	337,862		176,777	
24.	Cardiac Cath Lab	16,928,086	55,315,865	0.306026	2,891,191		884,780	
25.	Gastro Services	5,403,797	18,326,578	0.294861	432,560		127,545	
26.	Pulmonary	990,624	1,823,972	0.543114	94,013		51,060	
27.								
28.	Peripheral Vascular	1,305,989	7,113,945	0.183582	458,239		84,124	
29.								
30.	OBT Outpatient Center	8,203,399	20,500,244	0.400161	442		177	
31.	Organ Acquisition	5,202,111	9,836,045	0.528882	855,854		452,646	
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	47,656,908	78,389,875	0.607947	117,192		71,247	
44.	Emergency	12,169,645	75,420,370	0.161358	7,126,821		1,149,970	
45.	Observation	6,394,030	8,811,401	0.725654	8,065		5,852	
46.	Total				118,102,509		33,044,436	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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)	55,832,235		7,201,802	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	72,560		9,561	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	769.46		753.25	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,426			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,022,390			
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)	8,022,390			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	21,250,615	14,356	1,480.26	2,179	3,225,487
9.	Coronary Care Unit					
10.	Burn ICU	1,741,535	804	2,166.09	754	1,633,232
11.	NICU					
12.	PICU					
13.	Heart Transplant	4,342,695	2,944	1,475.10	349	514,810
14.	Bone ICU	4,249,094	3,677	1,155.59	394	455,302
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	665,868	1,399	475.96	242	115,182
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					33,044,436
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					47,010,839

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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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.	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 2552-10, 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)	
		(1)	(2)	(3)	(4)	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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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.								
28.	Peripheral Vascular							
29.								
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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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.	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)							

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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)		47,010,839	
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)		3,054,522	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		50,065,361	
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)		118,102,509	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		26,372,603	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		7,322,363	
F. Coronary Care Unit			
G. Burn ICU		6,955,030	
H. NICU			
I. PICU			
J. Heart Transplant		1,037,477	
K. Bone ICU		1,180,734	
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)		160,970,716	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			110,905,355
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

BHF Page 8

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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)	50,065,361	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	50,065,361	
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)	50,065,361	

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

BHF Page 9

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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)	110,905,355
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	Sum of Columns 1 - 4
		to	to	to		
		(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	4,739,799	172,436,779	0.027487	14,352,134		394,497	
2.	Recovery Room							
3.	Delivery and Labor Room	324,131	7,823,319	0.041431	3,513,810		145,581	
4.	Anesthesiology	3,166,434	59,875,606	0.052884	7,039,596		372,282	
5.	Radiology - Diagnostic	2,107,343	185,849,778	0.011339	6,740,931		76,435	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	397,036	22,241,224	0.017851	7,349,518		131,196	
8.	Laboratory	1,365,488	201,636,373	0.006772	16,057,471		108,741	
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	4,263,049	25,054,512	0.170151	530,609		90,284	
21.	Ambulance							
22.	Cancer Center	34,482	84,430,841	0.000408	239			
23.	Loyola OP Center,Psych Social Reh	5,724,998	91,857,025	0.062325	337,862		21,057	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary	230,537	1,823,972	0.126393	94,013		11,883	
27.								
28.	Peripheral Vascular							
29.								
30.	OBT Outpatient Center	612,795	20,500,244	0.029892	442		13	
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	112,313	78,389,875	0.001433	117,192		168	
44.	Emergency	1,762,523	75,420,370	0.023369	7,126,821		166,547	
45.	Observation							
46.	Ancillary Total						1,518,684	

* 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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	6,512,406	72,560	89.75	10,426		935,734	
48.	Psych							
49.	Rehab	314,279	9,561	32.87				
50.	Other (Sub)							
51.	Intensive Care Unit	2,012,930	14,356	140.22	2,179		305,539	
52.	Coronary Care Unit							
53.	Burn ICU	173,870	804	216.26	754		163,060	
54.	NICU							
55.	PICU							
56.	Heart Transplant	314,279	2,944	106.75	349		37,256	
57.	Bone ICU	879,568	3,677	239.21	394		94,249	
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						1,535,838	
68.	Ancillary Total (from line 46)						1,518,684	
69.	Total (Lines 67-68)						3,054,522	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	14,101	1	14,102
Newborn Days	242		242
Total Inpatient Revenue	191,217,118	(30,246,402)	160,970,716
Ancillary Revenue	118,102,509		118,102,509
Routine Revenue	73,114,609	(30,246,402)	42,868,207
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Per filed Medicare report W/S S-2, type of control is "Church".

**Burn ICU Beds, 1095 Days Available, and 804 Total Days Utilized were adjusted to same percentage as prior year.

**Bone ICU Total Days Utilized were adjusted to same percentage as prior year.

Medicaid Heart transplant days-349-includes 1 day from Ronald McDonald Children's Hospital.

Total costs and I&R costs are allocated for Adults & Peds, ICU, Burn ICU, and Bone ICU. See supplemental worksheet.

Removed from BHF Page 7 Room & Board (Routine) charges for Rehab, NICU, and Pediatrics ICU.

Adjusted BHF Page 3 costs to W/S C, Column 1.

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

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

Loyola O/P (90.07) costs and charges also includes Psych Social(90.03) from W/S C.

Clinic costs and charges from W/S C includes lines 90, 90.09 through 90.29.

** These were agreed to per conversation with Brad Hipp of Loyola-DW 8/08/2012.