

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 Ronald McDonald Children's 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: 07/01/2016	To: 06/30/2017

Type of Control

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

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) Children's

Health Care Program

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

☒ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

**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 07/01/2016 and ending 06/30/2017 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2016 To: 06/30/2017

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	12,395		2,778	22.41%		2,883	4.65
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	4	1,460		48	3.29%			
6.	Coronary Care Unit								
7.	Burn ICU	2	730		336	46.03%			
8.	NICU	50	18,250		7,870	43.12%			
9.	PICU	14	5,110		2,085	40.80%			
10.	Heart Transplant								
11.	Bone ICU	1	365		280	76.71%			
12.	Other								
13.									
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	105	38,310		13,397	34.97%		2,883	4.65
23.	Observation Bed Days				953				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,117			509	7.92
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				48				
6.	Coronary Care Unit								
7.	Burn ICU				15				
8.	NICU				2,372				
9.	PICU				478				
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.									
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				4,030	30.08%		509	7.92

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		13001	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 07/01/2016	To: 06/30/2017

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	48,536,064	154,646,124	0.313852				
2.	Recovery Room	6,612,762	53,294,170	0.124080				
3.	Delivery and Labor Room	4,742,607	13,656,105	0.347288				
4.	Anesthesiology	2,916,873	106,342,660	0.027429				
5.	Radiology - Diagnostic	29,696,821	342,939,155	0.086595				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	7,966,749	42,241,652	0.188599				
8.	Laboratory	32,717,943	481,510,688	0.067949				
9.	Blood							
10.	Blood - Administration	10,861,609	41,980,070	0.258733				
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,428,282	58,063,378	0.196824				
13.	Physical Therapy	3,404,695	13,285,563	0.256270				
14.	Occupational Therapy	1,406,358	7,063,603	0.199099				
15.	Speech Pathology	611,042	2,251,895	0.271346				
16.	EKG	5,004,291	53,640,440	0.093293				
17.	EEG	2,549,993	9,216,246	0.276685				
18.	Med. / Surg. Supplies	106,132,301	151,324,273	0.701357	353,680		248,056	
19.	Drugs Charged to Patients	108,297,045	313,740,360	0.345180				
20.	Renal Dialysis	5,646,695	37,023,381	0.152517				
21.	Ambulance	346,166						
22.	Cancer Center	22,347,721	26,287,603	0.850124				
23.	Loyola OP Center, Psych Social Reha	53,435,249	159,322,473	0.335391	11,094		3,721	
24.	Cardiac Cath Lab	15,932,634	117,011,656	0.136163				
25.	Gastro Services	6,126,188	43,345,884	0.141333				
26.	Pulmonary	1,028,018	5,038,974	0.204013				
27.	Other							
28.	Peripheral Vascular	1,480,635	15,885,247	0.093208				
29.	Other OP Clinics							
30.	OBT Outpatient Center	12,231,392	30,540,785	0.400494				
31.	Organ Acquisition	21,367,722	34,080,288	0.626982				
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	85,917,810	203,654,351	0.421881				
44.	Emergency	16,717,916	121,642,560	0.137435				
45.	Observation	12,294,567	31,873,348	0.385732	99,071		38,215	
46.	Total				463,845		289,992	

* 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: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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)	3,114,534			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	3,731			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	834.77			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,117			
3.	Program general inpatient routine cost (Line 1c X Line 2)	932,438			
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)	932,438			

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	64,430	48	1,342.29	48	64,430
9.	Coronary Care Unit					
10.	Burn ICU	1,551,116	336	4,616.42	15	69,246
11.	NICU	11,237,878	7,870	1,427.94	2,372	3,387,074
12.	PICU	4,091,605	2,085	1,962.40	478	938,027
13.	Heart Transplant					
14.	Bone ICU	634,717	280	2,266.85		
15.	Other					
16.						
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)					289,992
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					5,681,207

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: 07/01/2016 To: 06/30/2017

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.							
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:	13001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2016 To: 06/30/2017

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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2016 To: 06/30/2017

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.								
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: 13001	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2016 To: 06/30/2017	
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)	5,681,207	
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)	458,804	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	6,140,011	
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)	463,845	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,192,813	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	187,349	
	F. Coronary Care Unit		
	G. Burn ICU	211,854	
	H. NICU	9,434,234	
	I. PICU	2,420,942	
	J. Heart Transplant		
	K. Bone ICU		
	L. Other		
	M.		
	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)	16,911,037	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		10,771,026
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: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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)	6,140,011	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,140,011	
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)	6,140,011	

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:	13001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2016 To: 06/30/2017

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)	10,771,026
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)	(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: 13001
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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: 07/01/2016 To: 06/30/2017

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	9,521,088	154,646,124	0.061567				
2.	Recovery Room							
3.	Delivery and Labor Room	651,099	13,656,105	0.047678				
4.	Anesthesiology	6,360,585	106,342,660	0.059812				
5.	Radiology - Diagnostic	3,797,748	342,939,155	0.011074				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,232,932	42,241,652	0.029188				
8.	Laboratory	2,742,928	481,510,688	0.005697				
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	707,327	37,023,381	0.019105				
21.	Ambulance							
22.	Cancer Center	920,246	26,287,603	0.035007				
23.	Loyola OP Center, Psych Social Reha	10,579,866	159,322,473	0.066405	11,094		737	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Other							
28.	Peripheral Vascular							
29.	Other OP Clinics							
30.	OBT Outpatient Center	1,230,953	30,540,785	0.040305				
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	225,609	203,654,351	0.001108				
44.	Emergency	3,540,475	121,642,560	0.029106				
45.	Observation							
46.	Ancillary Total						737	

* 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: 07/01/2016 To: 06/30/2017

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	570,210	3,731	152.83	1,117		170,711	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	9,282	48	193.38	48		9,282	
52.	Coronary Care Unit							
53.	Burn ICU	273,338	336	813.51	15		12,203	
54.	NICU	389,868	7,870	49.54	2,372		117,509	
55.	PICU	647,141	2,085	310.38	478		148,362	
56.	Heart Transplant							
57.	Bone ICU	63,131	280	225.47				
58.	Other							
59.								
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						458,067	
68.	Ancillary Total (from line 46)						737	
69.	Total (Lines 67-68)						458,804	

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: 07/01/2016 To: 06/30/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,030		4,030
Newborn Days			
Total Inpatient Revenue	15,592,279	1,318,758	16,911,037
Ancillary Revenue	463,845		463,845
Routine Revenue	15,128,434	1,318,758	16,447,192
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.

Bone Marrow Procurement(All Other OP Clinics on filed) includes Occ. Health,Bariatrics, and Hepatology (lines 76.01,76.09, 76.10, and 76.11)

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 90.34.

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.

2016 Report: allocated Total Beds Available and Total Bed Days/Inpatient Days based on the PERCENTAGE OF LAST YEAR.