

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: 07/01/2019	To: 06/30/2020	

Type of Control

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

Type of Hospital

☒ General Short-Term XXXX XXXX	☐ 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 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 13027 for the cost report beginning 07/01/2019 and ending 06/30/2020 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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	311	113,826		78,965	69.37%		19,473	5.81
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	72	26,352		26,347	99.98%			
6.	Coronary Care Unit								
7.	Burn ICU	10	3,660		1,572	42.95%			
8.	NICU								
9.	PICU								
10.	Heart Transplant	10	3,660		2,651	72.43%			
11.	Bone ICU	10	3,660		3,660	100.00%			
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				5,865				
22.	Total	413	151,158		119,060	78.77%		19,473	5.81
23.	Observation Bed Days				8,525				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,040			768	12.60
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,829				
6.	Coronary Care Unit								
7.	Burn ICU				154				
8.	NICU								
9.	PICU								
10.	Heart Transplant				259				
11.	Bone ICU				395				
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				573				
22.	Total				10,250	8.61%		768	12.60

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:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	46,522,479	186,803,099	0.249046	3,896,881		970,503	
2.	Recovery Room	5,946,590	75,436,349	0.078829	1,522,792		120,040	
3.	Delivery and Labor Room	5,135,909	15,874,493	0.323532	745,867		241,312	
4.	Anesthesiology	1,799,513	117,976,988	0.015253	3,117,042		47,544	
5.	Radiology - Diagnostic	26,056,704	296,199,423	0.087970	6,483,402		570,345	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	3,082,790	45,773,785	0.067348	129,370		8,713	
8.	Laboratory	36,518,081	442,202,007	0.082582	10,541,437		870,533	
9.	Blood							
10.	Blood - Administration	11,743,216	41,808,879	0.280879	1,107,352		311,032	
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,823,772	69,627,869	0.169814	5,621,216		954,561	
13.	Physical Therapy	3,326,116	18,063,904	0.184131	888,515		163,603	
14.	Occupational Therapy	1,915,422	10,711,276	0.178823	532,392		95,204	
15.	Speech Pathology	890,509	4,302,357	0.206982	360,760		74,671	
16.	EKG	5,037,092	47,810,412	0.105356	1,034,257		108,965	
17.	EEG	2,706,799	13,571,898	0.199441	551,301		109,952	
18.	Med. / Surg. Supplies	124,371,129	148,497,169	0.837532	3,383,972		2,834,185	
19.	Drugs Charged to Patients	155,410,164	423,422,315	0.367033	6,941,662		2,547,819	
20.	Renal Dialysis	5,610,641	49,220,746	0.113989	489,496		55,797	
21.	Ambulance	830,855						
22.	Cancer Center	13,503,744	27,112,505	0.498063	5,763		2,870	
23.	Loyola OP Center, Psych Social Rehab	50,087,042	174,373,625	0.287240	280,826		80,664	
24.	Cardiac Cath Lab	13,776,312	115,530,899	0.119244	1,342,301		160,061	
25.	Gastro Services	7,605,952	84,148,908	0.090387	368,159		33,277	
26.	Pulmonary	999,718	5,771,515	0.173216	49,904		8,644	
27.	Hyperalimentation				1,350			
28.	Peripheral Vascular	1,527,393	17,476,309	0.087398	342,019		29,892	
29.	Other OP Clinics	5,471,190	4,350,346	1.257645				
30.	OBT Outpatient Center	14,963,320	28,402,319	0.526834	264		139	
31.	Organ Acquisition	27,850,382	66,924,121	0.416149				
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	88,707,178	185,922,431	0.477119	5,473		2,611	
44.	Emergency	18,178,889	133,982,129	0.135681	3,312,038		449,381	
45.	Observation	15,001,880	42,401,125	0.353809	624,909		221,098	
46.	Total				53,680,720		11,073,416	

* 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: 07/01/2019 To: 06/30/2020

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)	85,444,095			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	87,490			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	976.62			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,040			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,898,785			
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)	5,898,785			

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	29,638,891	26,347	1,124.94	2,829	3,182,455
9.	Coronary Care Unit					
10.	Burn ICU	7,104,016	1,572	4,519.09	154	695,940
11.	NICU					
12.	PICU					
13.	Heart Transplant	5,319,390	2,651	2,006.56	259	519,699
14.	Bone ICU	7,194,166	3,660	1,965.62	395	776,420
15.	Other					
16.	Reconcile ICUs to Filed					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,706,607	5,865	290.98	573	166,732
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					11,073,416
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					22,313,447

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: 07/01/2019 To: 06/30/2020

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)	
		(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: 07/01/2019 To: 06/30/2020

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.	Hyperalimentation							
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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0276		Medicaid Provider Number: 13027	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2019 To: 06/30/2020	
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)	22,313,447	
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)	2,565,684	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	24,879,131	
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)	53,680,720	
10.	Inpatient Routine Services (Provider's Records)		
A.	Adults and Pediatrics	14,535,343	
B.	Psych		
C.	Rehab		
D.	Other (Sub)		
E.	Intensive Care Unit	5,617,524	
F.	Coronary Care Unit		
G.	Burn ICU	305,659	
H.	NICU		
I.	PICU		
J.	Heart Transplant	487,403	
K.	Bone ICU	743,496	
L.	Other		
M.	Reconcile ICUs to Filed		
N.	Other		
O.	Other		
P.	Other		
Q.	Other		
R.	Other		
S.	Other		
T.	Nursery	1,078,069	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	76,448,214	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		51,569,083
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: 07/01/2019 To: 06/30/2020

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)	24,879,131	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	24,879,131	
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)	24,879,131	

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:	Medicaid Provider Number:
14-0276	13027
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2019 To: 06/30/2020

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)	51,569,083
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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(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: 07/01/2019 To: 06/30/2020

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:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	10,830,149	186,803,099	0.057976	3,896,881		225,926	
2.	Recovery Room							
3.	Delivery and Labor Room	740,619	15,874,493	0.046655	745,867		34,798	
4.	Anesthesiology	7,235,106	117,976,988	0.061326	3,117,042		191,156	
5.	Radiology - Diagnostic	4,013,751	296,199,423	0.013551	6,483,402		87,857	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,708,602	45,773,785	0.037327	129,370		4,829	
8.	Laboratory	3,120,055	442,202,007	0.007056	10,541,437		74,380	
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	526,763	49,220,746	0.010702	489,496		5,239	
21.	Ambulance							
22.	Cancer Center	1,046,772	27,112,505	0.038608	5,763		222	
23.	Loyola OP Center, Psych Social Reha	12,034,499	174,373,625	0.069016	280,826		19,381	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Other OP Clinics							
30.	OBT Outpatient Center	1,400,197	28,402,319	0.049299	264		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	256,628	185,922,431	0.001380	5,473		8	
44.	Emergency	4,027,258	133,982,129	0.030058	3,312,038		99,553	
45.	Observation							
46.	Ancillary Total						743,362	

* 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: 07/01/2019 To: 06/30/2020

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	15,895,880	87,490	181.69	6,040		1,097,408	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,032,060	26,347	153.04	2,829		432,950	
52.	Coronary Care Unit							
53.	Burn ICU	1,473,063	1,572	937.06	154		144,307	
54.	NICU							
55.	PICU							
56.	Heart Transplant	718,108	2,651	270.88	259		70,158	
57.	Bone ICU	718,108	3,660	196.20	395		77,499	
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)						1,822,322	
68.	Ancillary Total (from line 46)						743,362	
69.	Total (Lines 67-68)						2,565,684	

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	9,677		9,677
Newborn Days	573		573
Total Inpatient Revenue	76,448,214		76,448,214
Ancillary Revenue	53,680,720		53,680,720
Routine Revenue	22,767,494		22,767,494
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Operating Room costs and charges from W/S C include Ambulatory Surgery Center.

BHF Page 3 - Radiology-Diagnostic costs and charges from W/S C also include Radiology-Ultrasound, CT Scan, and MRI.

BHF Page 3 - Med Supplies costs and charges includes Implant Devices from W/S C.

BHF Page 3 - Loyola OP contains Psych Social Rehab and Loc O/P Center per W/S C

BHF Page 3 - All Other OP Clinics costs and charges includes Bone Marrow Proc, Bariatrics & Hepatology

BHF Page 3 - Clinic costs and charges from W/S C includes lines 90, 90.09 through 90.34 and 97

BHF Page 3 - Observation costs and charges include distinct and non-distinct

BHF Page 3 - Organ Acquisition costs came from W/S C, Column 1, Lines 105-112.

BHF Page 4 & BHF Supplemental 2b - Allocated GME costs between Adults & Peds, ICU and Burn ICU - see attached

BHF Page 3 - agreed the cost/charges to W/S C

BHF Page 1 - changed the Type of Control to Corp to agree with the Medicare Report

BHF Page 2 - changed the total beds for the Bone ICU to 10 from 9; changed the bed days available to 3660 from 3294; according to the Medicare report, the total utilized bone ICU days total 3660 which ties to the hospital cost report which means the Bone ICU is 100% utilized. Therefore, zeroed out the Bone ICU information on the Children's report since all is applicable to the Hospital.