

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 d/b/a Foster G. McGaw Hospital		Medicare Provider Number: 14-0276
Street: 2160 South First Avenue		Medicaid Provider Number: 13027
City: Maywood	State: Illinois	Zip: 60153
Period Covered by Statement:	From: 07/01/2006	To: 06/30/2007

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	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> 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 Cen 13027 for the cost report beginning 07/01/2006 and ending 06/30/2007; and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

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	Number Of Renal Dialysis Treatments
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics	277	101,261		72,211	71.31%		20,634	4.75	
2.	Rehabilitation Unit	24	8,760		8,279	94.51%		644	12.86	
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit	63	22,995		17,029	74.06%				
6.	Coronary Care Unit									
7.	Burn ICU	6	2,190		2,091	95.48%				
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU	9	3,285		3,481	105.97%				
11.	Bone ICU	13	4,745		3,152	66.43%				
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery	25	9,125		2,938	32.20%				
16.	Total	417	152,361		109,181	71.66%		21,278	4.99	
17.	Observation Bed Days				2,830					

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1.	Adults and Pediatrics				10,757			2,753	5.18	
2.	Rehabilitation Unit									
3.	Sub II									
4.	Sub III									
5.	Intensive Care Unit				2,257					
6.	Coronary Care Unit									
7.	Burn ICU				508					
8.	Neonatal ICU									
9.	Pediatric ICU									
10.	Heart Transplant ICU				320					
11.	Bone ICU				424					
12.	Other									
13.	Other									
14.	Other									
15.	Newborn Nursery				696					
16.	Total				14,962	13.70%		2,753	5.18	

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Other	Total Hospital
1.	Organized Clinic			
2.	Emergency Room			
3.	Private Referred			
4.	Total Emergency and Private Referred (Sum of Lines 2 and 3)			

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Line No.	Ancillary Service Cost Centers	Ratio of Cost to Charges (See Attached Supplement)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Organized O/P Clinic	Referred O/P E/R	I/P Expenses Applicable to Health Care Program (Col. 1 X 2)	Organized O/P Clinic	Referred O/P E/R
				Total Billed O/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients		O/P Expenses Applicable to Health Care Program (Col. 1 X 3)	O/P Expenses Applicable to Health Care Program (Col. 1 X 4)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room/ ASC	0.568367	8,937,440			5,079,746		
2.	Recovery Room	0.193887	1,655,115			320,905		
3.	Delivery and Labor Room	0.519473	4,162,695			2,162,408		
4.	Anesthesiology	0.216879	4,264,892			924,966		
5.	Radiology-Diagnostic,Ultrasound,M	0.339885	6,619,648			2,249,919		
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	0.395610	278,878			110,327		
8.	Laboratory-Surg Path, HLA	0.212891	10,260,968			2,184,468		
9.	Blood							
10.	Blood - Administration	0.475621	1,952,561			928,679		
11.	Intravenous Therapy							
12.	Respiratory Therapy	0.363003	3,075,814			1,116,530		
13.	Physical Therapy	0.486014	338,738			164,631		
14.	Occupational Therapy	0.455463	264,726			120,573		
15.	Speech Pathology	0.629182	142,475			89,643		
16.	EKG	0.323484	2,644,848			855,566		
17.	EEG	0.598688	260,865			156,177		
18.	Med. / Surg. Supplies	0.722151	1,856,430			1,340,623		
19.	Drugs Charged to Patients	0.305554	11,703,063			3,575,918		
20.	Renal Dialysis	0.469328	228,048			107,029		
21.	Ambulance	1.423353	228,352			325,026		
22.	Cancer Center	0.604047	458			277		
23.	Loyola OP Center/Psych social Ref	0.980617	157,872			154,812		
23.01	Cardiac Cath Lab	0.299338	1,733,867			519,012		
23.02	Gastro Services	0.345866	454,369			157,151		
23.03	Pulmonary Labs	0.529396						
23.04	Hyperalimentation	0.656734	279,532			183,578		
23.05	Peripheral Vascular	0.317343	250,139			79,380		
23.06	Occ. Health, Bone Marrow,Clinic	1.211185	208,569			252,616		
23.07	OBT Medical Center	0.610678	130			79		
23.08								
23.09	Organ Acquisition (from W/S D-6)	1.020549	922,069			941,017		
Outpatient Service Cost Centers								
24.	Clinic	1.203079	56			67		
25.	Emergency	0.546222	2,215,603			1,210,211		
26.	Observation	1.063562	3,529			3,753		
27.	Total		65,101,749			25,315,087		

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to HCFA 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: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Program Inpatient Operating Cost Before Capital Related and Medical Education Cost Adjustments

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Sub II	Sub III Sub III
1.	Adjusted general inpatient routine service cost per diem (See Instructions)	\$ 1,067.26	\$ 712.82	\$	\$
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,757			
3.	Program general inpatient routine cost (Line 1 X Line 2)	\$ 11,480,516	\$	\$	\$
4.	Average per diem private room cost differential (Supplement No. 1, Part II, Line 6)(Attached)	\$	\$	\$	\$
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)	\$ 11,480,516	\$	\$	\$

Line No.	Description	Average Per Diem (See Instructions)	Program Days	Program Cost (Col. A X Col. B)
		(A)	(B)	(C)
8.	Intensive Care Unit	\$ 1,878.03	2,257	\$ 4,238,714
9.	Coronary Care Unit	\$		\$
10.	Burn ICU	\$ 1,764.86	508	\$ 896,549
11.	Neonatal ICU	\$		\$
12.	Pediatric ICU	\$		\$
13.	Heart Transplant ICU	\$ 1,628.26	320	\$ 521,043
14.	Bone ICU	\$ 2,177.81	424	\$ 923,391
15.	Other	\$		\$
15.01	Other	\$		\$
15.02	Other	\$		\$
16.	Nursery	\$ 442.04	696	\$ 307,660
17.	Program inpatient ancillary care service cost (BHF Page 3, Col. 5, Line 27)			\$ 25,315,087
18.	Total Program Inpatient Operating Costs (Sum of Line 7 (Applicable Column) and 8 through 17)			\$ 43,682,960

**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: 07/01/2006 To: 06/30/2007

Line No.	Hospital Inpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Inpatient Days (BHF Page 2, Part I, Col. 4)	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.	Rehabilitation Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	Neonatal ICU						
10.	Pediatric ICU						
10.01	Heart Transplant ICU						
10.02	Bone ICU						
10.03	Other						
10.04	Other						
10.05	Other						
11.	Nursery						
12.	Subtotal Inpatient Care Svcs. (Lines 2 through 11)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (HCFA 2552, W/S D-2, Col. 1)	Expense Allocation (HCFA 2552, W/S D-2, Col. 2)	Total Dept. Charges (HCFA 2552, W/S C, Pt.1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges			Program Expenses (Col. 4 X Cols. 5A-C)		
						I / P	Org. Clinic	Ref. O / P	I / P	Org. Clinic	Ref. O / P
						(5A)	(5B)	(5C)	(6A)	(6B)	(6C)
13.	Clinic										
14.	Emergency										
15.	Observation										
16.	Subtotal Outpatient Care Svcs. (Lines 13 through 15)										
17.	Total (Sum of Lines 12 and 16)										

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Line No.	Cost Centers	Professional Component (HCFA 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (HCFA 2552, W/S C, Pt. 1, Per Dept.)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 2)	Outpatient Program Charges (BHF Page 3, Col. 3 & Col. 4)		Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for Hospital Based Physicians (Col. 3 X Col. 5)	
						Org. Clinic	Ref. O / P		Org. Clinic	Ref. O / P
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)		(6)	(7)	
1.	Operating Room/ ASC									
2.	Recovery Room									
3.	Delivery and Labor Room									
4.	Anesthesiology									
5.	Radiology-Diagnostic,Ultrasound,MR									
6.	Radiology - Therapeutic									
7.	Nuclear Medicine									
8.	Laboratory-Surg Path, HLA									
9.	Blood									
10.	Blood - Administration									
11.	Intravenous Therapy									
12.	Respiratory Therapy									
13.	Physical Therapy									
14.	Occupational Therapy									
15.	Speech Pathology									
16.	EKG									
17.	EEG									
18.	Med. / Surg. Supplies									
19.	Drugs Charged to Patients									
20.	Renal Dialysis									
21.	Ambulance									
22.	Cancer Center									
23.	Loyola OP Center/Psych social Reha									
23.01	Cardiac Cath Lab									
23.02	Gastro Services									
23.03	Pulmonary Labs									
23.04	Hyperalimentation									
23.05	Peripheral Vascular									
23.06	Occ. Health, Bone Marrow,Clinic									
23.07	OBT Medical Center									
23.08										
23.09	Organ Acquisition (from W/S D-6)									
Outpatient Ancillary Cost Centers										
24.	Clinic									
25.	Emergency									
26.	Observation									
Routine Service Cost Centers			Days	Per Diem	Days					
27.	Adults and Pediatrics									
28.	Rehabilitation Unit									
29.	Sub II									
30.	Sub III									
31.	Intensive Care Unit									
32.	Coronary Care Unit									
33.	Burn ICU									
34.	Neonatal ICU									
35.	Pediatric ICU									
35.01	Heart Transplant ICU									
35.02	Bone ICU									
35.03	Other									
35.04	Other									
35.05	Other									
36.	Nursery									
37.	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
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Ancillary Services (BHF Page 3, Line 27, Cols. 6 & 7)			
2.	Inpatient Operating Services (BHF Page 4, Line 18)	43,682,960		
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 17, Col. 6)			
4.	Hospital Based Physician Services (BHF Page 6, Line 37, Cols. 6 & 7)			
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7, 8, and 9)			
6.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 5)	43,682,960		
7.	Ratio of Inpatient, Organized Clinic and Referred O / P Cost to Total Cost (Line 6 Divided by Sum of Line 6, Cols. 1,2, and 3)	100.00%		

Line No.	Customary Charges	Program Inpatient and Outpatient
8.	Ancillary Services (See Instructions)	65,101,749
9.	Inpatient Routine Services (Provider's Records)	
	A. Adults and Pediatrics	12,098,065
	B. Rehabilitation Unit	
	C. Sub II	
	D. Sub III	
	E. Intensive Care Unit	6,106,868
	F. Coronary Care Unit	
	G. Burn ICU	1,550,093
	H. Neonatal ICU	
	I. Pediatric ICU	
	J. Heart Transplant ICU	901,135
	K. Bone ICU	1,137,542
	L. Other	
	M. Other	
	N. Other	
	O. Nursery	3,805,101
10.	Services of Teaching Physicians (Provider's Records)	
11.	Total Charges for Patient Services (Sum of Lines 8 through 10)	90,700,553
12.	Excess of Customary Charges Over Reasonable Cost (Line 11 Minus Line 6, Sum of Cols. 1 through 3)	47,017,593
13.	Excess of Reasonable Cost Over Customary Charges (Line 6, Sum of Cols. 1 through 3, Minus Line 11)	
14.	Excess Reasonable Cost Applicable to Inpatient, Org. Clinic and Referred Outpatient (Line 7, Each Column X Line 13)	

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Line No.	Allowable Cost	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 6, Cols. 1, 2, & 3)	43,682,960		
2.	Excess Reasonable Cost (BHF Page 7, Line 14, Columns 1, 2, & 3)			
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	43,682,960		
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B, 3B, & 4B)			
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With HCFA Pub. 15-II, Sec. 115.2 (B)			
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	43,682,960		

Line No.	Total Amount Received / Receivable	Inpatient Hospital (1)	Outpatient	
			Organized Clinic (2)	Referred Outpatient (3)
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: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006 To: 06/30/2007

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 12)	47,017,593
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)		
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 13)					
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		Organized Clinic		Referred O / P	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)	Ratio	Amount (Col. 1x4A)
			(1)	(2A)	(2B)	(3A)	(3B)	(4A)
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: 07/01/2006 To: 06/30/2007

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 (HCFA 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (HCFA 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Rehabilitation Ur	Sub II Sub II	Sub III Sub III
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program organized clinic occasions of service (BHF Page 2, Part III, Line 1)				
6. Program referred outpatient occasions of service (BHF page 2, Part III, Line 3)				

Part C. Program Cost

	General Service	Sub I Rehabilitation Ur	Sub II Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program organized clinic cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				
9. Program referred outpatient cost (Line 6 X Line 3) (to BHF Page 7, Col. 3, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Rehabilitation Ur	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (HCFA 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(HCFA 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (HCFA 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (HCFA 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (HCFA 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (HCFA 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (HCFA, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (HCFA 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (HCFA 2552, W/S B, Part I, Col. 25, Line 25,31,31.01, or 31.02 Less W/S D-1, Part I, Line 26) 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) (HCFA 2552, W/S B, Part I, Col. 25, Line 25, 31, 31.01, or 31.02 Less W/S D-1, Part 1, Line 26, Less Line 7 Above)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1)				

**Hospital Statement of Cost
Graduate Medical Education Cost Adjustment Sheet**

BHF Supplement No. 2

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027	
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2006	To: 06/30/2007

Computation of Cost Converters to Include Interns and Residents Cost Adjustment

Line No.	Cost Centers	Total Dept. Costs W/S B, Pt.1 Col. 25	Total Dept. Charges W/S C, Pt. 1	Adjusted Dept. Cost/ Charge Ratio (Transfer to BHF pgs. 3-4)
Inpatient Ancillary Centers				
1.	Operating Room/ ASC	85,190,731	149,886,733	0.568367
2.	Recovery Room	4,813,303	24,825,330	0.193887
3.	Delivery and Labor Room	6,067,065	11,679,266	0.519473
4.	Anesthesiology	11,669,372	53,805,812	0.216879
5.	Radiology-Diagnostic,Ultrasound,MRI,CT Scan	50,008,775	147,134,525	0.339885
6.	Radiology - Therapeutic			
7.	Nuclear Medicine	7,030,507	17,771,300	0.395610
8.	Laboratory-Surg Path, HLA	38,387,377	180,314,492	0.212891
9.	Blood			
10.	Blood - Administration	10,549,702	22,180,882	0.475621
11.	Intravenous Therapy			
12.	Respiratory Therapy	11,909,211	32,807,453	0.363003
13.	Physical Therapy	6,668,951	13,721,726	0.486014
14.	Occupational Therapy	2,667,070	5,855,738	0.455463
15.	Speech Pathology	939,347	1,492,965	0.629182
16.	EKG	21,075,315	65,151,012	0.323484
17.	EEG	2,822,357	4,714,239	0.598688
18.	Med. / Surg. Supplies	9,277,494	12,847,036	0.722151
19.	Drugs Charged to Patients	31,035,090	101,569,937	0.305554
20.	Renal Dialysis	10,043,642	21,400,068	0.469328
21.	Ambulance	4,814,201	3,382,297	1.423353
22.	Cancer Center	39,563,305	65,497,075	0.604047
23.	Loyola OP Center/Psych social Rehab	62,755,688	63,996,098	0.980617
23.01	Cardiac Cath Lab	13,714,169	45,814,987	0.299338
23.02	Gastro Services	5,408,292	15,636,973	0.345866
23.03	Pulmonary Labs	1,457,181	2,752,534	0.529396
23.04	Hyperalimentation	1,467,327	2,234,278	0.656734
23.05	Peripheral Vascular	1,643,467	5,178,841	0.317343
23.06	Occ. Health, Bone Marrow,Clinic	3,009,360	2,484,641	1.211185
23.07	OBT Medical Center	10,634,641	17,414,475	0.610678
23.08				
23.09	Organ Acquisition (from W/S D-6)	6,786,613	6,649,962	1.020549
Outpatient Ancillary Centers				
24.	Clinic	36,943,786	30,707,710	1.203079
25.	Emergency	25,696,948	47,044,874	0.546222
26.	Observation	444,069	417,530	1.063562
Routine Service Cost Centers			Total Days	Per Diem
27.	Adults and Pediatrics	80,088,178	75,041	1,067.26
28.	Rehabilitation Unit	5,901,427	8,279	712.82
29.	Sub II			
30.	Sub III			
31.	Intensive Care Unit	31,981,034	17,029	1,878.03
32.	Coronary Care Unit			
33.	Burn ICU	3,690,332	2,091	1,764.86
34.	Neonatal ICU			
35.	Pediatric ICU			
35.01	Heart Transplant ICU	5,667,967	3,481	1,628.26
35.02	Bone ICU	6,864,470	3,152	2,177.81
35.03	Other			
35.04	Other			
35.05	Other			
36.	Nursery	1,298,717	2,938	442.04

**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: 07/01/2006 To: 06/30/2007

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	14,461	(195)	14,266
Newborn Days	696		696
Total Inpatient Revenue	89,978,572	721,981	90,700,553
Ancillary Revenue	65,101,749		65,101,749
Routine Revenue	24,876,823	721,981	25,598,804
Inpatient Received and Receivable			
Organized Outpatient Clinic Reconciliation			
Organized Outpatient Clinic Visits			
Total Organized Outpatient Clinic Revenue			
Organized O/P Clinic Received and Receivable			
Referred Outpatient and ER Reconciliation			
Referred Outpatient Visits			
Total Referred Outpatient Revenue			
Referred Outpatient Received and Receivable			

Notes:

- Removed the 155 NICU days and 41 PICU days and respective charges and included with Ronald McDonald Children's Hospital cost report.
- Adjustment made to move \$879,967 Nursery charges from McDonald cost report to Foster McGaw cost report.
- Adjustment made to move 1 Bone ICU day from McDonald cost report to Foster McGaw cost report.
- Included the \$32,325 Rehab Room & Board charges with Adults & Peds.