

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information **PRELIMINARY**

Name of Hospital: Loyola University Medical Center DBA 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: 07/01/2007	To: 06/30/2008

Type of Control

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

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term XXXX XXXX	<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 XXXX XXXX	<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 Cer 13027 for the cost report beginning 07/01/2007 and ending 06/30/2008 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: 07/01/2007 To: 06/30/2008

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	271	99,308		75,373	75.90%		20,522	4.94
2.	Rehab	24	8,784		8,311	94.62%		617	13.47
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	63	23,058		16,955	73.53%			
6.	Coronary Care Unit								
7.	Burn ICU	6	2,196		2,184	99.45%			
8.	NICU								
9.	PICU								
10.	Heart Transplant	10	3,660		3,488	95.30%			
11.	Bone ICU	12	4,392		3,294	75.00%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				2,848				
22.	Total	386	141,398		112,453	79.53%		21,139	5.18
23.	Observation Bed Days				3,199				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				11,793			2,743	5.58
2.	Rehab								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				2,326				
6.	Coronary Care Unit								
7.	Burn ICU				478				
8.	NICU								
9.	PICU								
10.	Heart Transplant				288				
11.	Bone ICU				427				
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				416				
22.	Total				15,728	13.99%		2,743	5.58

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

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

PRELIMINARY

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	73,449,994	157,471,651	0.466433	9,282,492		4,329,661	
2.	Recovery Room	5,410,867	32,430,467	0.166845	2,225,772		371,359	
3.	Delivery and Labor Room	5,028,275	12,462,628	0.403468	4,317,876		1,742,125	
4.	Anesthesiology	5,560,711	56,634,162	0.098187	4,222,545		414,599	
5.	Radiology - Diagnostic	37,293,042	157,740,074	0.236421	7,675,752		1,814,709	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	5,595,903	18,136,342	0.308546	304,510		93,955	
8.	Laboratory	34,058,511	195,007,878	0.174652	10,920,085		1,907,215	
9.	Blood							
10.	Blood - Administration	9,496,405	22,865,121	0.415323	1,955,865		812,316	
11.	Intravenous Therapy							
12.	Respiratory Therapy	11,298,078	35,275,518	0.320281	2,881,059		922,748	
13.	Physical Therapy	5,589,685	12,858,225	0.434717	357,307		155,327	
14.	Occupational Therapy	2,463,268	6,346,735	0.388116	251,713		97,694	
15.	Speech Pathology	802,291	1,508,295	0.531919	171,097		91,010	
16.	EKG	18,875,194	63,402,600	0.297704	2,582,922		768,946	
17.	EEG	2,600,646	4,734,537	0.549293	217,316		119,370	
18.	Med. / Surg. Supplies	9,224,735	13,587,956	0.678891	1,743,090		1,183,368	
19.	Drugs Charged to Patients	30,797,647	111,127,967	0.277137	11,981,945		3,320,640	
20.	Renal Dialysis	9,076,077	22,407,310	0.405050	264,079		106,965	
21.	Ambulance	778,192	320,539	2.427761	50,335		122,201	
22.	Cancer Center	37,603,634	69,904,822	0.537926	2,667		1,435	
23.	Loyola OP Center	55,970,177	90,931,003	0.615524	284,255		174,966	
24.	Cardiac Cath Lab	11,983,279	48,608,645	0.246526	1,954,728		481,891	
25.	Gastro Services	5,083,733	15,224,298	0.333922	465,552		155,458	
26.	Hyperalimentation	101,691	215,692	0.471464	27,368		12,903	
27.	Peripheral Vascular	1,552,551	5,011,193	0.309817	334,398		103,602	
28.	Organ Acquisition	7,864,724	7,864,724	1.000000	559,864		559,864	
29.	Other							
30.	Other							
31.	Other							
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	38,017,778	38,713,041	0.982041	373,439		366,732	
44.	Emergency	15,032,362	51,317,885	0.292926	2,716,428		795,712	
45.	Observation	3,822,765	5,228,802	0.731098	4,793		3,504	
46.	Total				68,129,252		21,030,275	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehab	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	66,329,834	5,543,718		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	78,572	8,311		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	844.19	667.03		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	11,793			
3.	Program general inpatient routine cost (Line 1c X Line 2)	9,955,533			
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)	9,955,533			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	27,010,677	16,955	1,593.08	2,326	3,705,504
9.	Coronary Care Unit					
10.	Burn ICU	2,722,763	2,184	1,246.69	478	595,918
11.	NICU					
12.	PICU					
13.	Heart Transplant	4,455,455	3,488	1,277.37	288	367,883
14.	Bone ICU	4,749,951	3,294	1,442.00	427	615,734
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,182,847	2,848	415.33	416	172,777
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					21,030,275
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					36,443,624

**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: 07/01/2007 To: 06/30/2008

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Rehab						
4.	Sub II						
5.	Sub III						
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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

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

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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							
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Hyperalimentation							
27.	Peripheral Vascular							
28.	Organ Acquisition							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

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

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Rehab							
49.	Sub II							
50.	Sub III							
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**

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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)	36,443,624	
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)	3,702,456	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	40,146,080	
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)	68,129,252	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	14,117,692	
	B. Rehab		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	5,824,858	
	F. Coronary Care Unit		
	G. Burn ICU	1,117,968	
	H. NICU		
	I. PICU		
	J. Heart Transplant	757,390	
	K. Bone ICU	1,284,400	
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,407,495	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	93,639,055	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		53,492,975
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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)	40,146,080	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	40,146,080	
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	40,146,080	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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 13)	53,492,975
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			1.	Cost Report Period ended		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 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 Rehab	Sub II Sub II	Sub III Sub III
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 Rehab	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 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 Rehab	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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 1)				

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: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	7,365,992	157,471,651	0.046777	9,282,492		434,207	
2.	Recovery Room							
3.	Delivery and Labor Room	503,723	12,462,628	0.040419	4,317,876		174,524	
4.	Anesthesiology	4,920,869	56,634,162	0.086889	4,222,545		366,893	
5.	Radiology - Diagnostic	3,274,965	157,740,074	0.020762	7,675,752		159,364	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	617,023	18,136,342	0.034021	304,510		10,360	
8.	Laboratory	2,122,067	195,007,878	0.010882	10,920,085		118,832	
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	53,588	69,904,822	0.000767	2,667		2	
23.	Loyola OP Center	9,849,393	90,931,003	0.108317	284,255		30,790	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Hyperalimentation							
27.	Peripheral Vascular							
28.	Organ Acquisition							
29.	Other							
30.	Other							
31.	Other							
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	174,542	38,713,041	0.004509	373,439		1,684	
44.	Emergency	2,739,089	51,317,885	0.053375	2,716,428		144,989	
45.	Observation							
46.	Ancillary Total						1,441,645	

* 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: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	10,150,815	78,572	129.19	11,793		1,523,538	
48.	Rehab							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	3,190,859	16,955	188.20	2,326		437,753	
52.	Coronary Care Unit							
53.	Burn ICU	351,147	2,184	160.78	478		76,853	
54.	NICU							
55.	PICU							
56.	Heart Transplant	488,412	3,488	140.03	288		40,329	
57.	Bone ICU	1,406,610	3,294	427.02	427		182,338	
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						2,260,811	
68.	Ancillary Total (from line 46)						1,441,645	
69.	Total (Lines 67-68)						3,702,456	

**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: 07/01/2007 To: 06/30/2008

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	15,227	85	15,312
Newborn Days	416		416
Total Inpatient Revenue	93,754,540	(115,485)	93,639,055
Ancillary Revenue	68,130,988	(1,736)	68,129,252
Routine Revenue	25,623,552	(113,749)	25,509,803
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- Removed the 172 NICU days and 87 PICU days and included with Ronald McDonald Children's Hospital cost report
- Removed \$1,736 of home health/hospice charges since non-covered by IL medicaid
- The Operating Room Costs & charges include Ambulatory Surgery
- Radiology includes Ultrasound, MRI, & Cat Scan
- Laboratory includes surgical pathology and HLA
- Included \$877 for sub charges with acute charges
- Adjustment made to move \$113,749 of PICU charges to Ronald McDonald's Children's Hospital
- Reclassified blood as Blood-Admin
- Organ Acquisition costs and charges taken from W/S D-6 Line 51
- Included \$372,693 of all other OP Clinics with Clinic charges