

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 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: 07/01/2008	To: 06/30/2009

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 type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) XXXX XXXX Children's

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 13001 for the cost report beginning 07/01/2008 and ending 06/30/2009 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:	13001
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	12,410		7,933	63.92%		3,709	6.55
2.									
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	1	365		37	10.14%			
6.	Coronary Care Unit								
7.	Burn ICU	5	1,825		1,301	71.29%			
8.	NICU	50	18,250		12,876	70.55%			
9.	PICU	14	5,110		2,136	41.80%			
10.	Heart Transplant								
11.	Bone ICU	1	365		11	3.01%			
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	105	38,325		24,294	63.39%		3,709	6.55
23.	Observation Bed Days				1,152				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,549			1,933	6.43
2.									
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				11				
6.	Coronary Care Unit								
7.	Burn ICU				137				
8.	NICU				6,621				
9.	PICU				1,114				
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				12,432	51.17%		1,933	6.43

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:	13001
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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, ASC	86,780,816	165,876,004	0.523167	2,655,808		1,389,431	
2.	Recovery Room	6,729,910	35,279,429	0.190760	745,861		142,280	
3.	Delivery and Labor Room	4,606,526	10,007,184	0.460322				
4.	Anesthesiology	6,555,604	59,712,379	0.109786	1,372,536		150,685	
5.	Radiology - Diagnostic,Ultrasound,MF	39,685,712	176,417,970	0.224953	2,323,943		522,778	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	5,958,321	21,866,805	0.272482	16,738		4,561	
8.	Laboratory,Surg Path,HLA	36,630,100	201,326,147	0.181944	5,212,609		948,403	
9.	Blood							
10.	Blood - Administration	10,761,473	21,448,941	0.501725	308,328		154,696	
11.	Intravenous Therapy							
12.	Respiratory Therapy	12,340,222	38,999,199	0.316422	4,912,213		1,554,332	
13.	Physical Therapy	6,643,844	15,045,146	0.441594	127,810		56,440	
14.	Occupational Therapy	2,433,659	6,235,935	0.390264	152,494		59,513	
15.	Speech Pathology	938,296	1,846,206	0.508229	136,016		69,127	
16.	EKG	24,994,125	68,206,728	0.366447	461,774		169,216	
17.	EEG	2,866,943	5,122,523	0.559674	150,422		84,187	
18.	Med. / Surg. Supplies	10,572,434	13,237,830	0.798653	679,514		542,696	
19.	Drugs Charged to Patients	38,521,671	105,917,499	0.363695	4,709,560		1,712,843	
20.	Renal Dialysis	9,930,824	22,888,752	0.433874	3,049		1,323	
21.	Ambulance	398,079	165,904	2.399454	10,020		24,043	
22.	Cancer Center	42,784,293	74,303,770	0.575802				
23.	Loyola OP Center,Psych Social Reha	51,477,706	77,408,261	0.665016	31,376		20,866	
24.	Cardiac Cath Lab	17,920,078	55,551,853	0.322583	88,109		28,422	
25.	Gastro Services	5,970,458	17,142,754	0.348279	15,595		5,431	
26.	Pulmonary	1,075,442	1,980,007	0.543151				
27.	Hyperalimentation							
28.	Peripheral Vascular	1,502,772	5,963,223	0.252007	14,820		3,735	
29.	Clinic, Occ Hlth, Bone Marrow Proc	2,768,995	2,199,072	1.259165	868		1,093	
30.	OBT Medical Center	9,844,590	20,150,958	0.488542				
31.	Organ Acquisition[from W/S D-6]	9,484,783	9,484,783	1.000000	125,389		125,389	
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	40,108,315	41,249,972	0.972323	407		396	
44.	Emergency	15,438,023	53,128,622	0.290578	1,217,110		353,665	
45.	Observation (Non-distinct)	5,855,022	7,549,133	0.775589				
46.	Total				25,472,369		8,125,551	

* 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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I	Sub II	Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	8,351,813			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	9,085			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	919.30			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,549			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,181,896			
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)	4,181,896			

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	66,660	37	1,801.62	11	19,818
9.	Coronary Care Unit					
10.	Burn ICU	2,062,692	1,301	1,585.47	137	217,209
11.	NICU	15,960,079	12,876	1,239.52	6,621	8,206,862
12.	PICU	3,756,024	2,136	1,758.44	1,114	1,958,902
13.	Heart Transplant					
14.	Bone ICU	17,233	11	1,566.63		
15.	Other					
16.	Other					
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)					8,125,551
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					22,710,238

**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 [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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.							
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 (Non-distinct)								
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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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, ASC							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic,Ultrasound,MRI							
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 Rehab							
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Clinic, Occ Hlth, Bone Marrow Proc							
30.	OBT Medical Center							
31.	Organ Acquisition[from W/S D-6]							
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 (Non-distinct)							
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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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.								
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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	22,710,238	
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)	1,247,280	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	23,957,518	
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)	25,472,369	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	6,290,571	
	B.		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	38,695	
	F. Coronary Care Unit		
	G. Burn ICU	1,291,505	
	H. NICU	17,821,193	
	I. PICU	2,777,415	
	J. Heart Transplant		
	K. Bone ICU		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	53,691,748	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		29,734,230
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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	23,957,518	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	23,957,518	
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)	23,957,518	

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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	29,734,230
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: 13001
Program: Medicaid-Hospital [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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	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	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	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:	13001
Program:	Medicaid-Hospital [Children's]	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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, ASC	6,008,836	165,876,004	0.036225	2,655,808		96,207	
2.	Recovery Room							
3.	Delivery and Labor Room	410,914	10,007,184	0.041062				
4.	Anesthesiology	4,014,217	59,712,379	0.067226	1,372,536		92,270	
5.	Radiology - Diagnostic, Ultrasound, M	2,671,564	176,417,970	0.015143	2,323,943		35,191	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	503,338	21,866,805	0.023018	16,738		385	
8.	Laboratory, Surg Path, HLA	1,731,084	201,326,147	0.008598	5,212,609		44,818	
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	112,424	22,888,752	0.004912	3,049		15	
21.	Ambulance							
22.	Cancer Center	43,714	74,303,770	0.000588				
23.	Loyola OP Center, Psych Social Reh	7,257,814	77,408,261	0.093760	31,376		2,942	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary	292,261	1,980,007	0.147606				
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Clinic, Occ Hlth, Bone Marrow Proc							
30.	OBT Medical Center	776,865	20,150,958	0.038552				
31.	Organ Acquisition[from W/S D-6]							
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	142,384	41,249,972	0.003452	407		1	
44.	Emergency	2,234,423	53,128,622	0.042057	1,217,110		51,188	
45.	Observation (Non-distinct)							
46.	Ancillary Total						323,017	

* 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 [Children's]	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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	934,226	9,085	102.83	4,549		467,774	
48.								
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	6,431	37	173.82	11		1,912	
52.	Coronary Care Unit							
53.	Burn ICU	349,136	1,301	268.36	137		36,765	
54.	NICU	408,416	12,876	31.72	6,621		210,018	
55.	PICU	398,424	2,136	186.53	1,114		207,794	
56.	Heart Transplant							
57.	Bone ICU	3,741	11	340.13				
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						924,263	
68.	Ancillary Total (from line 46)						323,017	
69.	Total (Lines 67-68)						1,247,280	

