

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62762

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: 07/01/2022	To: 06/30/2023

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
<input 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

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 type="checkbox"/> Other (Specify)

Health Care Program

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

<input type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/>

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 Center 13027 for the cost report beginning 07/01/2022 and ending 06/30/2023 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 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: 07/01/2022 To: 06/30/2023

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	310	113,150		77,738	68.70%		16,641	6.31
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	72	26,280		14,994	57.05%			
6.	Coronary Care Unit								
7.	Burn ICU	10	3,650		3,475	95.21%			
8.	NICU								
9.	PICU								
10.	Heart Transplant	10	3,650		5,173	141.73%			
11.	Bone ICU	10	3,650		3,650	100.00%			
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				4,222				
22.	Total	412	150,380		109,252	72.65%		16,641	6.31
23.	Observation Bed Days				7,429				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,045			646	11.56
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,660				
6.	Coronary Care Unit								
7.	Burn ICU				242				
8.	NICU								
9.	PICU								
10.	Heart Transplant				233				
11.	Bone ICU				289				
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				294				
22.	Total				7,763	7.11%		646	11.56

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: 07/01/2022 To: 06/30/2023

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	57,214,411	238,095,217	0.240301	4,321,409		1,038,439	
2.	Recovery Room	6,334,606	82,573,690	0.076715	1,246,557		95,630	
3.	Delivery and Labor Room	5,076,301	12,505,084	0.405939	455,017		184,709	
4.	Anesthesiology	2,141,672	156,115,553	0.013719	3,866,642		53,046	
5.	Radiology - Diagnostic	26,264,139	324,461,005	0.080947	6,968,299		564,063	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	3,317,712	58,619,382	0.056598	70,908		4,013	
8.	Laboratory	32,986,638	464,423,977	0.071027	9,584,452		680,755	
9.	Blood							
10.	Blood - Administration	12,380,575	41,936,150	0.295224	1,617,755		477,600	
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,123,669	64,313,236	0.204059	3,836,515		782,875	
13.	Physical Therapy	3,078,689	16,946,770	0.181668	706,998		128,439	
14.	Occupational Therapy	2,003,286	11,522,189	0.173863	494,780		86,024	
15.	Speech Pathology	986,683	4,516,748	0.218450	280,006		61,167	
16.	EKG	4,390,010	56,007,616	0.078382	1,081,267		84,752	
17.	EEG	2,924,254	15,030,611	0.194553	383,224		74,557	
18.	Med. / Surg. Supplies	123,835,573	174,217,837	0.710809	3,341,987		2,375,514	
19.	Drugs Charged to Patients	207,292,807	467,987,221	0.442945	5,683,334		2,517,404	
20.	Renal Dialysis	7,265,521	45,553,172	0.159495	827,056		131,911	
21.	Ambulance	579,961						
22.	Cancer Center	11,459,364	20,351,135	0.563082	3,047		1,716	
23.	Loyola OP Center, Psych Social Reha	55,864,789	162,940,506	0.342854	258,893		88,763	
24.	Cardiac Cath Lab	13,357,498	122,254,180	0.109260	1,124,641		122,878	
25.	Gastro Services	9,281,742	120,270,749	0.077174	454,884		35,105	
26.	Pulmonary	1,279,186	6,544,465	0.195461	45,502		8,894	
27.	Hyperalimentation							
28.	Peripheral Vascular	2,085,038	16,805,180	0.124071	296,032		36,729	
29.	Bariatrics	851,366	184,970	4.602725				
30.	OBT Outpatient Center	12,494,512	42,810,997	0.291853				
31.	Organ Acquisition	47,006,091	93,782,907	0.501222	2,121,849		1,063,517	
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	68,537,504	206,611,193	0.331722	8,677		2,878	
44.	Emergency	18,229,337	139,780,846	0.130414	2,679,040		349,384	
45.	Observation	12,906,437	52,792,376	0.244475	1,106,572		270,529	
46.	Total				52,865,343		11,321,291	

* If Medicare claims billed net of professional component, total hospital professional component charge 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: 07/01/2022 To: 06/30/2023

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 c swing bed and private room cost differential) (see instructions)	82,801,331			
b)	Total inpatient days including private room day: (CMS 2552-10, W/S S-3, Part 1, Col. 8)	85,167			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	972.22			
2.	Program general inpatient routine day: (BHF Page 2, Part II, Col. 4)	5,045			
3.	Program general inpatient routine cos (Line 1c X Line 2)	4,904,850			
4.	Average per diem private room cost differential: (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicabl to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicabl to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cos (Line 3 + Line 6)	4,904,850			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	29,281,012	14,994	1,952.85	1,660	3,241,731
9.	Coronary Care Unit					
10.	Burn ICU	8,529,832	3,475	2,454.63	242	594,020
11.	NICU					
12.	PICU					
13.	Heart Transplant	5,871,198	5,173	1,134.97	233	264,448
14.	Bone ICU	5,876,172	3,650	1,609.91	289	465,264
15.	Other					
16.	Reconcile ICUs to Filed					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,475,139	4,222	349.39	294	102,721
24.	Program inpatient ancillary care service cos (BHF Page 3, Col. 6, Line 46)					11,321,291
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					20,894,325

**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: 07/01/2022 To: 06/30/2023

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2022 To: 06/30/2023

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 Rehat							
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Bariatrics							
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 charge 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: 07/01/2022 To: 06/30/2023

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-Hospita	Period Covered by Statement: From: 07/01/2022 To: 06/30/2023

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)		20,894,325	
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)		2,362,081	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		23,256,406	
8. Ratio of Inpatient and Outpatient Cost to Total Cos (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)		52,865,343	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		18,683,023	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		5,703,759	
F. Coronary Care Unit			
G. Burn ICU		830,357	
H. NICU			
I. PICU			
J. Heart Transplant		790,816	
K. Bone ICU		978,635	
L. Other			
M. Reconcile ICUs to Filed			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		998,405	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		80,850,338	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			57,593,932
14. Excess of Reasonable Cost Over Customary Charge (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: 07/01/2022 To: 06/30/2023

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Service (BHF Page 7, Line 7, Cols. 1 & 2)	23,256,406	
2.	Excess Reasonable Cos (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cos (Line 1 Minus Line 2)	23,256,406	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charge: (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)	23,256,406	

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number:	14-0276	Medicaid Provider Number:	13027
Program:	Medicaid-Hospital	Period Covered by Statement:	
		From:	07/01/2022 To: 06/30/2023

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)	57,593,932
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

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

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

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2022 To: 06/30/2023

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 Revenue:				
(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 day: (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: 07/01/2022 To: 06/30/2023

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	11,081,108	238,095,217	0.046541	4,321,409		201,123	
2.	Recovery Room							
3.	Delivery and Labor Room	757,782	12,505,084	0.060598	455,017		27,573	
4.	Anesthesiology	7,402,761	156,115,553	0.047418	3,866,642		183,348	
5.	Radiology - Diagnostic	4,420,003	324,461,005	0.013623	6,968,299		94,929	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,434,947	58,619,382	0.024479	70,908		1,736	
8.	Laboratory	3,192,354	464,423,977	0.006874	9,584,452		65,884	
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	538,969	45,553,172	0.011832	827,056		9,786	
21.	Ambulance							
22.	Cancer Center	1,071,028	20,351,135	0.052627	3,047		160	
23.	Loyola OP Center, Psych Social Reh	12,313,367	162,940,506	0.075570	258,893		19,565	
24.	Cardiac Cath Lab							
25.	Gastro Services							
26.	Pulmonary							
27.	Hyperalimentation							
28.	Peripheral Vascular							
29.	Bariatrics							
30.	OBT Outpatient Center	1,432,644	42,810,997	0.033464				
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	262,574	206,611,193	0.001271	8,677		11	
44.	Emergency	4,120,579	139,780,846	0.029479	2,679,040		78,975	
45.	Observation							
46.	Ancillary Total						683,090	

* If Medicare claims billed net of professional component, total hospital professional component charge 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: 07/01/2022 To: 06/30/2023

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	16,923,027	85,167	198.70	5,045		1,002,442	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,298,465	14,994	286.68	1,660		475,889	
52.	Coronary Care Unit							
53.	Burn ICU	1,570,777	3,475	452.02	242		109,389	
54.	NICU							
55.	PICU							
56.	Heart Transplant	734,749	5,173	142.04	233		33,095	
57.	Bone ICU	734,749	3,650	201.30	289		58,176	
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)						1,678,991	
68.	Ancillary Total (from line 46)						683,090	
69.	Total (Lines 67-68)						2,362,081	

Preliminary

Medicare Provider Number: 14-0276	Medicaid Provider Number: 13027
Program: Medicaid-Hospita	Period Covered by Statement: From: 07/01/2022 To: 06/30/2023

Inpatient Reconciliator	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,468	1	7,469
Newborn Days	294		294
Total Inpatient Revenue	80,850,338		80,850,338
Ancillary Revenue	52,865,344	(1)	52,865,343
Routine Revenue	27,984,994	1	27,984,995
Inpatient Received and Receivable			
Outpatient Reconciliator			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Reclassified the NICU I/P days to the children's report since no NICU beds and days on the Adult repc
BHF Page 2 - changed the total beds for the Bone ICU to 10 from 9; changed the bed days available to 3650 from 3285
there is no utilization on the Children's report; I/P days on adult report agree with the total bed days available for 10 be
BHF Page 3 - Operating Room costs and charges from W/S C include Ambulatory Surgery Center costs & charge
BHF Page 3 - Radiology-Diagnostic costs and charges from W/S C also include Rad-Ultrasound, CT Scan & MF
BHF Page 3 - Med Supplies costs and charges includes Implant Devices from W/S C
BHF Page 3 - All Other OP Clinics costs and charges includes Bariatrics
BHF Page 3 - Loyola OP contains Psych Social Rehab and Loc O/P Center per W/S C
BHF Page 3 - Clinic costs and charges from W/S C includes lines 90, 90.09 through 90.32 and 97
BHF Page 3 - Observation costs and charges include distinct and non-distinc
BHF Page 3 - Organ Acquisition costs came from W/S C, Column 1, Lines 105-109.
BHF Page 3 - Reclassified Blood to Blood Admir
BHF Page 3 - Adjusted Costs/charges to agree with W/S C, Col 1 & 2 of the Medicare repoi
BHF Page 4 & BHF Supplemental 2b - Allocated Routine costs and GME costs between Adults & Peds, ICU an
Burn ICU - see attached spreadshee
BHF Page 4 - Adjusted out the NICU costs as all are reported on the children's report as hospital reported all beds and bed da
bed days available for NICU on the Children's repoi
BHF Supplemental 2a & 2b - Agreed the GME costs from W/S B, Part I, Col 25 to the Medicare report; adjusted out the
stepdown cost from Renal Dialysis and Loyola OP Cente
Minor rounding adjustment!
Adjusted out the OP information as only governmental hospitals need repor