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

Type of Control

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

Type of Hospital

XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

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

XXXX	Medicaid Hospita		Medicaid Sub II Rehab		
	Medicaid Sub I Psych		Medicaid Sub III Other		

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishab 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 Balan Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s Loyola University Medical Ce 13001 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 an complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as note

Prepared by (Signed)

Signed (Officer or Administrator of Provider(s))

Name (Typewritten)		Name (Typewritten)	
Title	Date	Title	
Firm		Date	
Telephone Number		Telephone Number	
Email Address		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 befo the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Cente

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	34	12,410		1,034	8.33%		2,389	6.21
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	4	1,460		199	13.63%			
6.	Coronary Care Unit								
7.	Burn ICU	2	730		46	6.30%			
8.	NICU	50	18,250		10,222	56.01%			
9.	PICU	14	5,110		3,334	65.24%			
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**104**	**37,960**		**14,835**	**39.08%**		**2,389**	**6.21**
23.	Observation Bed Days				666				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				464			228	4.01
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				22				
6.	Coronary Care Unit								
7.	Burn ICU				3				
8.	NICU				192				
9.	PICU				233				
10.	Heart Transplant								
11.	Bone ICU								
12.	Other								
13.	Reconcile ICUs to Filed								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**914**	**6.16%**		**228**	**4.01**

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:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	Total Dept. Charges (CMS 2552-10, 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	57,214,411	238,095,217	0.240301				
2.	Recovery Room	6,334,606	82,573,690	0.076715				
3.	Delivery and Labor Room	5,076,301	12,505,084	0.405939				
4.	Anesthesiology	2,141,672	156,115,553	0.013719				
5.	Radiology - Diagnostic	26,264,139	324,461,005	0.080947				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	3,317,712	58,619,382	0.056598				
8.	Laboratory	32,986,638	464,423,977	0.071027				
9.	Blood							
10.	Blood - Administration	12,380,575	41,936,150	0.295224				
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,123,669	64,313,236	0.204059				
13.	Physical Therapy	3,078,689	16,946,770	0.181668				
14.	Occupational Therapy	2,003,286	11,522,189	0.173863				
15.	Speech Pathology	986,683	4,516,748	0.218450				
16.	EKG	4,390,010	56,007,616	0.078382				
17.	EEG	2,924,254	15,030,611	0.194553				
18.	Med. / Surg. Supplies	123,835,573	174,217,837	0.710809				
19.	Drugs Charged to Patients	207,292,807	467,987,221	0.442945				
20.	Renal Dialysis	7,265,521	45,553,172	0.159495				
21.	Ambulance	579,961						
22.	Cancer Center	11,459,364	20,351,135	0.563082				
23.	Loyola OP Center,Psych Social Reha	55,864,789	162,940,506	0.342854	28		10	
24.	Cardiac Cath Lab	13,357,498	122,254,180	0.109260				
25.	Gastro Services	9,281,742	120,270,749	0.077174				
26.	Pulmonary	1,279,186	6,544,465	0.195461				
27.	Hyperalimentation							
28.	Peripheral Vascular	2,085,038	16,805,180	0.124071				
29.	Bariatrics	851,366	184,970	4.602725				
30.	OBT Outpatient Center	12,494,512	42,810,997	0.291853				
31.	Organ Acquistion	47,006,091	93,782,907	0.501222				
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				
44.	Emergency	18,229,337	139,780,846	0.130414				
45.	Observation	12,906,437	52,792,376	0.244475	16,400		4,009	
46.	**Total**				**16,428**		**4,019**	

* If Medicare claims billed net of professional component, total hospital professional component charg
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:	Medicaid Provider Number:			
14-0276		13001		
Program:	Period Covered by Statement:			
Medicaid-Hospital	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	1,652,779			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	1,700			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	972.22			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	464			
3.	Program general inpatient routine cos (Line 1c X Line 2)	451,110			
4.	Average per diem private room cost differentia (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)	451,110			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	388,617	199	1,952.85	22	42,963
9.	Coronary Care Unit					
10.	Burn ICU	112,913	46	2,454.63	3	7,364
11.	NICU	8,502,034	10,222	831.74	192	159,694
12.	PICU	3,876,132	3,334	1,162.61	233	270,888
13.	Heart Transplant					
14.	Bone ICU					
15.	Other					
16.	Reconcile ICUs to Filed					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cos (BHF Page 3, Col. 6, Line 46)					4,019
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**936,038**

Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	NICU						
10.	PICU						
11.	Heart Transplant						
12.	Bone ICU						
13.	Other						
14.	Reconcile ICUs to Filed						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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 Acquistion							
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 charg
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:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospita	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)	936,038	
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)	161,022	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,097,060**	
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)	16,428	
10.	Inpatient Routine Services (Provider's Records		
	A. Adults and Pediatrics	3,521,607	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	167,186	
	F. Coronary Care Uni		
	G. Burn ICU	24,276	
	H. NICU	2,112,439	
	I. PICU	2,560,532	
	J. Heart Transplant		
	K. Bone ICU		
	L. Other		
	M. Reconcile ICUs to Filed		
	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)**	8,402,468	
13.	Excess of Customary Charges Over Reasonable Co (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		7,305,408
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 Outpatier (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Service (BHF Page 7, Line 7, Cols. 1 & 2)	1,097,060	
2.	Excess Reasonable Cos (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cos (Line 1 Minus Line 2)	1,097,060	
4.	Recovery of Excess Reasonable Cost Unde Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**1,097,060**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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 Cos (BHF Page 7, Line 13)	7,305,408
2.	Carry Over of Excess Reasonable Cos (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cos (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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cos (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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospita	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 Service

1.	Physicians on hospital staff average per dien (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per dien (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 servic (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3 (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swin bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excludin swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per dien (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per dien (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per dien (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 adjustmen (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed an 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:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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				
2.	Recovery Room							
3.	Delivery and Labor Room	757,782	12,505,084	0.060598				
4.	Anesthesiology	7,402,761	156,115,553	0.047418				
5.	Radiology - Diagnostic	4,420,003	324,461,005	0.013623				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,434,947	58,619,382	0.024479				
8.	Laboratory	3,192,354	464,423,977	0.006874				
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				
21.	Ambulance							
22.	Cancer Center	1,071,028	20,351,135	0.052627				
23.	Loyola OP Center,Psych Social Reh	12,313,367	162,940,506	0.075570	28		2	
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 Acquistion							
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				
44.	Emergency	4,120,579	139,780,846	0.029479				
45.	Observation							
46.	**Ancillary Total**						**2**	

* If Medicare claims billed net of professional component, total hospital professional component charg
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:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	337,797	1,700	198.70	464		92,197	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	57,049	199	286.68	22		6,307	
52.	Coronary Care Unit							
53.	Burn ICU	20,793	46	452.02	3		1,356	
54.	NICU	453,747	10,222	44.39	192		8,523	
55.	PICU	753,175	3,334	225.91	233		52,637	
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)**						**161,020**	
68.	**Ancillary Total (from line 46)**						**2**	
69.	**Total (Lines 67-68)**						**161,022**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0276	13001
Program:	**Period Covered by Statement:**
Medicaid-Hospita	From: 07/01/2022 To: 06/30/2023

Inpatient Reconciliatior	Provider's Records	Adjustments	Audited Cost Report
Adult Days	915	(1)	914
Newborn Days			
Total Inpatient Revenue	8,402,469	(1)	8,402,468
Ancillary Revenue	16,428		16,428
Routine Revenue	8,386,041	(1)	8,386,040
Inpatient Received and Receivable			
Outpatient Reconciliatior			
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 repo
BHF Page 2 - Changed the total beds for the Bone ICU to 0 from 1; changed the bed days available to 0 from 36
there is no utilization on the Children's report; I/P days are all reported on the Adult as-filed cost repo
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 repo
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 - All the NICU costs are reported on the children's report as hospital reported all beds and bed da
available for NICU on the Children's repor
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