Hospital Statement of Cost

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

General Information

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Name of Hospital: Rockford Memorial Hospital (combined)			**Medicare Provider Number:** 14-0239
Street: 2400 North Rockton			**Medicaid Provider Number:** 18005
City: Rockford	**State:** Illinois	**Zip:** 61103-3655	
Period Covered by Statement:	**From:** 07/01/2016	**To:** 06/30/2017	

Type of Control

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

Type of Hospital

XXXX 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 XXXX	Medicaid Hospital		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 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)) Rockford Memorial Hospital (c 18005 for the cost report beginning 07/01/2016 and ending 06/30/2017 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

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 5 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

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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	240	86,767		39,144	45.11%		12,257	4.79
2.	Psych	14	5,110		3,633	71.10%		622	5.84
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	21	7,175		4,141	57.71%			
6.	Coronary Care Unit								
7.	NeoNatal ICU	52	18,278		14,321	78.35%			
8.	Pediatric ICU	7	2,555		1,074	42.04%			
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	21	7,665		3,080	40.18%			
22.	**Total**	**355**	**127,550**		**65,393**	**51.27%**		**12,879**	**4.84**
23.	Observation Bed Days				6,430				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,328			1,485	7.56
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				664				
6.	Coronary Care Unit								
7.	NeoNatal ICU				5,885				
8.	Pediatric ICU				351				
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				815				
22.	**Total**				**12,043**	**18.42%**		**1,485**	**7.56**

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

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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	24,616,781	68,288,775	0.360481	2,675,301		964,395	
2.	Recovery Room	2,111,066	8,183,482	0.257967	277,359		71,549	
3.	Delivery and Labor Room	7,525,115	21,061,452	0.357293	2,799,510		1,000,245	
4.	Anesthesiology	3,078,913	13,215,694	0.232974	591,872		137,891	
5.	Radiology - Diagnostic	7,824,285	51,996,685	0.150477	2,263,596		340,619	
6.	Radiology - Therapeutic	3,966,058	9,746,946	0.406903	19,449		7,914	
7.	Nuclear Medicine	1,742,653	10,291,947	0.169322	94,380		15,981	
8.	Laboratory	13,473,600	77,569,574	0.173697	5,370,495		932,839	
9.	Blood							
10.	Blood - Administration	1,717,979	10,589,149	0.162240	1,077,918		174,881	
11.	Intravenous Therapy	631,571	42,642,571	0.014811	440,443		6,523	
12.	Respiratory Therapy	5,684,130	32,601,104	0.174354	6,148,575		1,072,029	
13.	Physical Therapy	2,778,792	7,587,060	0.366254	453,922		166,251	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,724,628	33,146,807	0.112368	1,060,294		119,143	
17.	EEG	1,520,143	9,006,043	0.168791	272,331		45,967	
18.	Med. / Surg. Supplies	17,923,169	174,082,214	0.102958	15,038,324		1,548,316	
19.	Drugs Charged to Patients	29,971,481	171,144,321	0.175124	7,718,927		1,351,769	
20.	Renal Dialysis	838,795	1,265,134	0.663009	116,514		77,250	
21.	Ambulance	934,059	741,930	1.258958	177,728		223,752	
22.	Implants	20,582,308	88,911,599	0.231492	3,420,102		791,726	
23.	GI Lab	1,848,796	8,338,277	0.221724	129,680		28,753	
24.	MRI	1,589,087	25,166,292	0.063143	562,580		35,523	
25.	CT Scan	1,830,456	64,929,981	0.028191	1,569,595		44,248	
26.	Cardiac Cath	4,011,658	23,157,276	0.173235	698,072		120,931	
27.	Special Surgical Serv	812,166	3,090,732	0.262775				
28.	Genetic Services	576,002	368,291	1.563986	4,865		7,609	
29.	Pain Center	1,781,074	10,873,915	0.163793	4,915		805	
30.	Antenatal Test Center	1,750,356	13,279,275	0.131811	108,621		14,317	
31.	Child Psychiatric Clinic	643,770	312,224	2.061885	504		1,039	
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							
44.	Emergency	15,302,857	50,330,893	0.304045	949,988		288,839	
45.	Observation	6,864,797	9,905,225	0.693048	98,215		68,068	
46.	**Total**				**54,144,075**		**9,659,172**	

* 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 - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:		
14-0239	18005		
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 07/01/2016	To:	06/30/2017

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 of swing bed and private room cost differential) (see instructions)	48,627,849	3,476,376		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,574	3,633		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,067.01	956.89		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,328			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,618,019			
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)	4,618,019			

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	8,479,541	4,141	2,047.70	664	1,359,673
9.	Coronary Care Unit					
10.	NeoNatal ICU	11,963,013	14,321	835.35	5,885	4,916,035
11.	Pediatric ICU	2,349,266	1,074	2,187.40	351	767,777
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	6,369,028	3,080	2,067.87	815	1,685,314
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					9,659,172
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**23,005,990**

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

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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.	NeoNatal ICU						
9.	Pediatric ICU						
10.	Other						
11.	Other						
12.	Other						
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 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

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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	118,408	68,288,775	0.001734	2,675,301		4,639	
2.	Recovery Room							
3.	Delivery and Labor Room	1,068,808	21,061,452	0.050747	2,799,510		142,067	
4.	Anesthesiology	1,524,525	13,215,694	0.115357	591,872		68,277	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	388,027	77,569,574	0.005002	5,370,495		26,863	
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.	Implants							
23.	GI Lab							
24.	MRI							
25.	CT Scan							
26.	Cardiac Cath	33,604	23,157,276	0.001451	698,072		1,013	
27.	Special Surgical Serv							
28.	Genetic Services							
29.	Pain Center							
30.	Antenatal Test Center							
31.	Child Psychiatric Clinic							
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**						**242,859**	

* 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 - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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	382,733	45,574	8.40	4,328		36,355	
48.	Psych	75,275	3,633	20.72				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NeoNatal ICU							
54.	Pediatric ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**36,355**	
68.	**Ancillary Total (from line 46)**						**242,859**	
69.	**Total (Lines 67-68)**						**279,214**	

Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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)	23,005,990	
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)	279,214	
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)	85,954	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**23,371,158**	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	54,144,075	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,291,716	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,065,490	
	F. Coronary Care Unit		
	G. NeoNatal ICU	25,393,991	
	H. Pediatric ICU	1,477,277	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	361,138	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	85,733,687	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		62,362,529
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 - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:		
14-0239	18005		
Program:	**Period Covered by Statement:**		
Medicaid Hospital	From: 07/01/2016	To:	06/30/2017

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	23,371,158	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	23,371,158	
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, Ch. 1, Sec. 115.2		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**23,371,158**	

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 - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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)	62,362,529
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 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 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 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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	**Medicaid Provider Number:**
14-0239	**18005**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2016 To: 06/30/2017**

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 Revenues				
	(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 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 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 - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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							
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.	Implants							
23.	GI Lab							
24.	MRI							
25.	CT Scan							
26.	Cardiac Cath							
27.	Special Surgical Serv							
28.	Genetic Services							
29.	Pain Center							
30.	Antenatal Test Center							
31.	Child Psychiatric Clinic							
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							
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 G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

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	905,025	45,574	19.86	4,328		85,954	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NeoNatal ICU							
54.	Pediatric ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**85,954**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**85,954**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary - Revised 06/28/18 for DSH (see notes last page)

Medicare Provider Number:	Medicaid Provider Number:
14-0239	18005
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2016 To: 06/30/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,918	5,310	11,228
Newborn Days	1,504	(689)	815
Total Inpatient Revenue	56,288,375	29,445,312	85,733,687
Ancillary Revenue	37,572,733	16,571,342	54,144,075
Routine Revenue	18,715,642	12,873,970	31,589,612
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Rockford Memorial amended their 06/30/17 Medicaid cost report for DSH on 06/28/18 as if they were two providers, Rockford and Rockford Children's. As of 07/01/18, the provider was not enrolled as such. BRDA indicated that the separate reports would not be accepted. In order to preserve the right for the provider to file amended reports for DSH, the two reports were combined and presented in this report.

Separate Medicare reports for Adult and Children were also submitted, but could not be accepted as Medicare will also not accept. The original combined Medicare was used to complete this report.