

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 05/21/2015 Time: 19:04 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCKFORD MEMORIAL HOSPITAL (14-0239) (Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		1,035,347	220,372	-17,733		1
2	SUBPROVIDER - IPF		11,128				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,046,475	220,372	-17,733		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2400 N ROCKTON AVENUE	P.O. Box:		1
2	City: ROCKFORD	State: IL	ZIP Code: 61103	County: WINNEBAGO

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ROCKFORD MEMORIAL HOSPITAL	14-0239	40420	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	RMH PSYCHIATRIC UNIT	14-S239	40420	4	03 / 01 / 1990	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2014	To: 12 / 31 / 2014	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	17,553	2,465		79	3,468	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

			1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)		N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)		N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	I	2	3	
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	Y	N	45
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	46
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	Y			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)	N	N		71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N			80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N			81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational Speech Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.	N		110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, Section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118
118.01	List amounts of malpractice premiums and paid losses: 6,546,027	Premiums	Paid Losses	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1 Y	2 149018	140
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If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: ROCKFORD HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICE Contractor's Number: 65235			141
142	Street: 2400 NORTH ROCKTON AVENUE	P.O. Box:			142
143	City: ROCKFORD	State: IL	ZIP Code: 61103		143
144	Are provider based physicians' costs included in Worksheet A?	Y			144
145	If costs for renal services are claimed on Worksheet A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y			145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2014	12 / 31 / 2014		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement		Y/N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/17/2015	Y	04/17/2015
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relieved for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

Home Office Costs		Y/N	Date	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: GARY	Last name: ZEMAN	Title: VICE PRESIDENT
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC		
43	Phone number: 630-530-7100	E-mail Address: GARY.ZEMAN@SRGROUPLLC.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	237	82,844			18,562	8,919	43,081	1
2	HMO and other (see instructions)						6,028	3,468		2
3	HMO IPF Subprovider						183	129		3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		237	82,844			18,562	8,919	43,081	7
8	Intensive Care Unit	31	21	7,665			2,133	1,101	5,185	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
11.01	NEONATAL INTENSIVE CARE	34.01	46	16,790				7,489	11,956	11.01
11.02	PEDIATRIC INTENSIVE CARE	34.02	7	2,555				643	1,026	11.02
12	Other Special Care (specify)	35								12
13	Nursery	43						1,713	2,735	13
14	Total (see instructions)		311	109,854			20,695	19,865	63,983	14
15	CAH Visits									15
16	Subprovider - IPF	40	14	5,110			995	1,112	4,120	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		325							27
28	Observation Bed Days								4,694	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							232	1,920	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					4,307	4,854	12,681	1
2	HMO and other (see instructions)					1,221			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
11.01	NEONATAL INTENSIVE CARE								11.01
11.02	PEDIATRIC INTENSIVE CARE								11.02
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		1,650.78			4,307	4,854	12,681	14
15	CAH Visits								15
16	Subprovider - IPF		24.95			135	242	681	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		1,675.73						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	108,564,468	-8,880,811	99,683,657	3,494,838.00	28.52	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		2,689,024	-202,157	2,486,867	66,836.00	37.21	10
OTHER WAGES & RELATED COSTS							
11		2,055,260		2,055,260	38,812.00	52.95	11
12							12
13		7,462,218		7,462,218	80,620.00	92.56	13
14		21,387,016		21,387,016	454,890.00	47.02	14
15							15
16							16
WAGE-RELATED COSTS							
17		32,909,663		32,909,663			17
18		558,333		558,333			18
19		629,996		629,996			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		2,453,132	-952,775	1,500,357	83,867.00	17.89	26
27		18,382,059	-7,375,689	11,006,370	238,783.00	46.09	27
28			11,938,191	11,938,191	36,237.00	329.45	28
29							29
30		2,747,941	-154,162	2,593,779	113,305.00	22.89	30
31		100,449		100,449	8,078.00	12.43	31
32		1,974,532		1,974,532	150,902.00	13.08	32
33			33,338	33,338	2,434.00	13.70	33
34		2,259,337	-1,523,429	735,908	53,208.00	13.83	34
35			401,808	401,808	7,680.00	52.32	35
36			1,523,429	1,523,429	110,146.00	13.83	36
37							37
38		3,468,484		3,468,484	108,123.00	32.08	38
39		1,351,928		1,351,928	80,025.00	16.89	39
40		3,881,754		3,881,754	96,604.00	40.18	40
41		1,410,485	-135,978	1,274,507	52,045.00	24.49	41
42		326,696	-60,050	266,646	8,235.00	32.38	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	108,564,468	3,492,526	112,056,994	3,541,189.00	31.64	1
2	Excluded area salaries (see instructions)	2,689,024	-202,157	2,486,867	66,836.00	37.21	2
3	Subtotal salaries (line 1 minus line 2)	105,875,444	3,694,683	109,570,127	3,474,353.00	31.54	3
4	Subtotal other wages & related costs (see instructions)	30,904,494		30,904,494	574,322.00	53.81	4
5	Subtotal wage-related costs (see instructions)	33,467,996		33,467,996		30.54%	5
6	Total (sum of lines 3 through 5)	170,247,934	3,694,683	173,942,617	4,048,675.00	42.96	6
7	Total overhead cost (see instructions)	38,356,797	3,694,683	42,051,480	1,149,672.00	36.58	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	2,226,546	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	2,431,258	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	17,605,236	8
9	Prescription Drug Plan	418	9
10	Dental, Hearing and Vision Plan	629,126	10
11	Life Insurance (If employee is owner or beneficiary)	29,552	11
12	Accident Insurance (If employee is owner or beneficiary)	869	12
13	Disability Insurance (If employee is owner or beneficiary)	1,315,403	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)	8,300	14
15	Workers' Compensation Insurance	1,004,562	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	463,481	16
	TAXES		
17	FICA-Employers Portion Only	6,805,918	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	296,371	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	711,733	23
24	Total Wage Related cost (Sum of lines 1-23)	33,528,773	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	569,218	25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date	09/30/2018	1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2014	2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S) 11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOnths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	2,251,318	33,069,455	1
2	Hospital	2,055,260	32,909,663	2
3	Subprovider - IPF	196,058	159,792	3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)			10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP X	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.290742	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		43,459,735	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		16,302,498	5
6	Medicaid charges		205,084,608	6
7	Medicaid cost (line 1 times line 6)		59,626,709	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care				17
18	Government grants, appropriations of transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	6,278,606	29,206,433	35,485,039	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,825,454	8,491,537	10,316,991	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	1,825,454	8,491,537	10,316,991	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)			7,944,117	26
27	Medicare bad debts for the entire hospital complex (see instructions)			1,156,616	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			6,787,501	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,973,412	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			12,290,403	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			12,290,403	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				231,288	231,288	-58,684	172,604	1
2	00200	Cap Rel Costs-Mvble Equip				15,158,779	15,158,779	-6,668	15,152,111	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	2,453,132	2,610,444	5,063,576	4,403,815	9,467,391	-1,490,622	7,976,769	4
5	00500	Administrative & General	18,382,059	89,019,169	107,401,228	-7,667,320	99,733,908	-41,093,998	58,639,910	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,747,941	11,007,025	13,754,966	-1,315,195	12,439,771	-201,041	12,238,730	7
8	00800	Laundry & Linen Service	100,449	930,395	1,030,844	-7,830	1,023,014		1,023,014	8
9	00900	Housekeeping	1,974,532	1,485,551	3,460,083	-23,835	3,436,248	-48,980	3,387,268	9
10	01000	Dietary	2,259,337	3,122,645	5,381,982	-3,696,687	1,685,295		1,685,295	10
11	01100	Cafeteria				3,628,971	3,628,971	-1,800,510	1,828,461	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	3,468,484	1,131,079	4,599,563	-23,848	4,575,715	-129,665	4,446,050	13
14	01400	Central Services & Supply	1,351,928	2,169,492	3,521,420	-375,391	3,146,029	-1,118	3,144,911	14
15	01500	Pharmacy	3,881,754	13,944,749	17,826,503	-12,401,538	5,424,965		5,424,965	15
16	01600	Medical Records & Library	1,410,485	1,620,701	3,031,186	-231,782	2,799,404	-38,882	2,760,522	16
17	01700	Social Service	326,696	181,474	508,170	-137,901	370,269		370,269	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	PARAMEDICAL ED PROGRAM XRAY	154,901	41,024	195,925	-90	195,835	-31,202	164,633	23
23.01	02301	PASTORAL EDUCATION PROGRAM				78,870	78,870	-5,300	73,570	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	388,328	340,336	728,664	20,506	749,170	-106,071	643,099	23.02
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	20,242,533	11,233,333	31,475,866	-3,491,122	27,984,744	-52,424	27,932,320	30
31	03100	Intensive Care Unit	3,969,795	4,220,078	8,189,873	-759,049	7,430,824		7,430,824	31
34.01	03401	NEONATAL INTENSIVE CARE	1,351,928	3,905,299	10,686,625	-2,828,311	7,858,314	-57,216	7,801,098	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	1,071,242	682,513	1,753,755	-61,411	1,692,344		1,692,344	34.02
40	04000	Subprovider - IPF	1,379,072	879,010	2,258,082	-64,250	2,193,832	-37,700	2,156,132	40
43	04300	Nursery				2,764,964	2,764,964		2,764,964	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	7,122,696	24,877,831	32,000,527	-16,632,370	15,368,157	9,489,593	24,857,750	50
51	05100	Recovery Room	945,364	410,541	1,355,905	-31,553	1,324,352		1,324,352	51
52	05200	Delivery Room & Labor Room	2,505,349	2,744,528	5,249,877	-531,430	4,718,447	-856,899	3,861,548	52
53	05300	Anesthesiology	343,009	3,401,784	3,744,793	-234,828	3,509,965	-1,609,552	1,900,413	53
54	05400	Radiology-Diagnostic	2,594,431	3,764,218	6,358,649	-2,247,291	4,111,358	-1,780	4,109,578	54
55	05500	Radiology-Therapeutic	909,178	870,352	1,779,530	-309,959	1,469,571		1,469,571	55
56	05600	Radioisotope	221,134	988,207	1,209,341	-368,335	841,006		841,006	56
60	06000	Laboratory	6,066,460	14,287,050	20,353,510	-693,767	19,659,743	-9,262,084	10,397,659	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	179,641	1,302,326	1,481,967	-181,313	1,300,654		1,300,654	63
65	06500	Respiratory Therapy	2,264,136	2,011,619	4,275,755	-452,378	3,823,377	-17,447	3,805,930	65
66	06600	Physical Therapy	533,826	1,238,425	1,772,251	-4,955	1,767,296		1,767,296	66
69	06900	Electrocardiology	1,124,008	816,247	1,940,255	-381,789	1,558,466		1,558,466	69
70	07000	Electroencephalography	579,544	501,865	1,081,409	-243,482	837,927		837,927	70
71	07100	Medical Supplies Charged to Patients				10,378,625	10,378,625		10,378,625	71
72	07200	Impl. Dev. Charged to Patients				15,644,349	15,644,349		15,644,349	72
73	07300	Drugs Charged to Patients				12,167,825	12,167,825		12,167,825	73
74	07400	Renal Dialysis		769,004	769,004	-37,135	731,869		731,869	74
76	03340	GI LAB	418,045	722,348	1,140,393	-413,531	726,862		726,862	76
76.01	03450	MRI	469,467	812,595	1,282,062	-514,548	767,514		767,514	76.01
76.02	03290	CT SCAN	654,213	674,689	1,328,902	-281,469	1,047,433		1,047,433	76.02
76.03	03141	CARDIAC CATHETERIZATION	913,464	5,195,564	6,109,028	-4,482,322	1,626,706	-116,738	1,509,968	76.03
76.04	03950	PRIMARY PREVENTION PROGRAM								76.04
76.05	03951	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	03952	OUTPATIENT DETOX								76.07
76.08	03953	SPECIAL SURGICAL SERVICES	222,787	262,961	485,748	-87,093	398,655		398,655	76.08
76.10	03955	GENETIC SERVICES	749,404	604,794	1,354,198	-234,990	1,119,208	-71,395	1,047,813	76.10
76.11	03140	CARDIOLOGY								76.11
76.12	03550	OUTPATIENT PSYCH SERVICES								76.12
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09003	PAIN CENTER	507,237	462,466	969,703	-201,781	767,922		767,922	90.01
90.02	09001	ANTENATAL TEST CENTER	351,071	306,863	657,934	-38,269	619,665	-31,872	587,793	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	324,748	98,142	422,890	-2,528	420,362	-20	420,342	90.03
91	09100	Emergency	5,454,539	4,331,950	9,786,489	-1,433,926	8,352,563	-109,767	8,242,796	91

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	135,926	556,429	692,355	-10,252	682,103	-73,850	608,253	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	107,933,671	220,537,115	328,470,786	1,341,138	329,811,924	-47,821,892	281,990,032	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		1,091,264	1,091,264	-2,179	1,089,085		1,089,085	192
193.0 1	19301	BELOIT HEART STANDBY	57,857	12,179	70,036		70,036		70,036	193.0 1
194	07950	GUEST CENTER	69,131	301,231	370,362	-6,344	364,018	-118,854	245,164	194
194.0 1	07954	OTHER NONREIMBURSEABLE COST CENTER								194.0 1
194.0 2	07951	COMMUNITY SERVICES	384,020	1,852,984	2,237,004	-1,330,516	906,488		906,488	194.0 2
194.0 4	07952	AUXILIARY	119,789	390,495	510,284	-2,099	508,185		508,185	194.0 4
194.0 7	07953	ROCKFORD HEALTH SYSTEM								194.0 7
194.0 8	07955	DIALYSIS RENTED SPACE								194.0 8
200		TOTAL (sum of lines 118-199)	108,564,468	224,185,268	332,749,736		332,749,736	-47,940,746	284,808,990	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	DRUGS CHARGED TO PATIENTS	1		3			
		2					
		3					
		4					
		5					
500	Total reclassifications	A	Drugs Charged to Patients	73		12,167,825	1
	Code Letter - A					12,167,825	500
1	EMT MEDICAL DIRECTOR	D	PARAMED EDUC EMT PROGRAM	23.02		30,000	1
500	Total reclassifications					30,000	500
	Code Letter - D						
1	SHARED DIETARY EXPENSES	E	Cafeteria	11	1,523,429	2,105,542	1
500	Total reclassifications				1,523,429	2,105,542	500
	Code Letter - E						
1	RECLASS MED SUPPLIES CHGD PAT	F	Medical Supplies Charged to P	71		10,378,625	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
500	Total reclassifications					10,378,625	500
	Code Letter - F						
1	NURSERY COSTS	G	Nursery	43	494,833	261,029	1
2			Nursery	43	1,282,284	726,818	2
500	Total reclassifications				1,777,117	987,847	500
	Code Letter - G						
1	DEPARTMENTAL DEPRECIATION	H	Cap Rel Costs-Mvble Equip	2		15,158,779	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
500	Total reclassifications					15,158,779	500
	Code Letter - H						
1	INSURANCE RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		231,288	1
2							2
3							3
500	Total reclassifications					231,288	500
	Code Letter - I						
1	PASTORAL EDUCATION PROGRAM	J	PASTORAL EDUCATION PROGRAM	23.01	52,408	26,462	1
500	Total reclassifications				52,408	26,462	500
	Code Letter - J						
1	IMPLANTS	K	Impl. Dev. Charged to Patient	72		15,644,349	1
2							2
3							3
500	Total reclassifications					15,644,349	500
	Code Letter - K						
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4		952,775	1
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5		7,323,281	2
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7		154,162	3
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16		135,978	4
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17		60,050	5
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02		254,565	6
500	Total reclassifications					8,880,811	500
	Code Letter - L						
1	SHARED SERVICES DIRECT COST ASSIGNE	M	Employee Benefits Department	4		4,423,619	1
2	SHARED SERVICES DIRECT COST ASSIGNE	M					2
3	SHARED SERVICES DIRECT COST ASSIGNE	M					3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
500	Total reclassifications					4,423,619	500
	Code Letter - M						
	GRAND TOTAL (Increases)				3,352,954	70,035,147	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DRUGS CHARGED TO PATIENTS	A	Pharmacy	15		12,167,825	1	
500	Total reclassifications					12,167,825	500	
	Code letter - A							
1	EMT MEDICAL DIRECTOR	D	Administrative & General	5		30,000	1	
500	Total reclassifications					30,000	500	
	Code letter - D							
1	SHARED DIETARY EXPENSES	E	Dietary	10	1,523,429	2,105,542	1	
500	Total reclassifications				1,523,429	2,105,542	500	
	Code letter - E							
1	RECLASS MED SUPPLIES CHGD PAT	F	Central Services & Supply	14		41,863	1	
2			Adults & Pediatrics	30		1,317,967	2	
3			Intensive Care Unit	31		498,072	3	
4			NEONATAL INTENSIVE CARE	34.01		567,418	4	
5			PEDIATRIC INTENSIVE CARE	34.02		47,732	5	
6			Subprovider - IPF	40		6,298	6	
7			Operating Room	50		3,657,957	7	
8			Recovery Room	51		23,404	8	
9			Delivery Room & Labor Room	52		264,143	9	
10			Anesthesiology	53		21,973	10	
11			Radiology-Diagnostic	54		1,003,716	11	
12			Radiology-Therapeutic	55		38,984	12	
13			Radioisotope	56		364,766	13	
14			Blood Storing, Processing & T	63		157,883	14	
15			Respiratory Therapy	65		268,200	15	
16			Physical Therapy	66		1,340	16	
17			Electrocardiology	69		81,182	17	
18			Electroencephalography	70		55,665	18	
19			Renal Dialysis	74		12,423	19	
20			GI LAB	76		110,177	20	
21			MRI	76.01		14,586	21	
22			CT SCAN	76.02		99,686	22	
23			CARDIAC CATHETERIZATION	76.03		658,686	23	
24			SPECIAL SURGICAL SERVICES	76.08		11,900	24	
25			GENETIC SERVICES	76.10		117,466	25	
26			PAIN CENTER	90.01		135,970	26	
27			ANTENATAL TEST CENTER	90.02		8,686	27	
28			CHILD PSYCHIATRIC CLINIC	90.03		518	28	
29			Emergency	91		785,810	29	
30			Ambulance Services	95		1,339	30	
31			Physicians' Private Offices	192		2,179	31	
32			GUEST CENTER	194		15	32	
33			COMMUNITY SERVICES	194.02		621	33	
500	Total reclassifications					10,378,625	500	
	Code letter - F							
1	NURSERY COSTS	G	Adults & Pediatrics	30	494,833	261,029	1	
2			NEONATAL INTENSIVE CARE	34.01	1,282,284	726,818	2	
500	Total reclassifications				1,777,117	987,847	500	
	Code letter - G							
1	DEPARTMENTAL DEPRECIATION	H	Employee Benefits Department	4		19,804	9	
2			Administrative & General	5		5,248,129	2	
3			Operation of Plant	7		1,080,777	3	
4			Laundry & Linen Service	8		7,830	4	
5			Housekeeping	9		23,835	5	
6			Dietary	10		67,716	6	
7			Nursing Administration	13		23,848	7	
8			Central Services & Supply	14		333,528	8	
9			Pharmacy	15		233,713	9	
10			Medical Records & Library	16		28,439	10	
11			PARAMDICAL ED PROGRAM XRAY	23		90	11	
12			PARAMED EDUC EMT PROGRAM	23.02		9,494	12	
13			Adults & Pediatrics	30		1,417,293	13	
14			Intensive Care Unit	31		260,977	14	
15			NEONATAL INTENSIVE CARE	34.01		251,791	15	
16			PEDIATRIC INTENSIVE CARE	34.02		13,679	16	
17			Subprovider - IPF	40		57,952	17	
18			Operating Room	50		1,359,396	18	
19			Recovery Room	51		8,149	19	
20			Delivery Room & Labor Room	52		267,287	20	
21			Anesthesiology	53		212,855	21	

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
22			Radiology-Diagnostic	54		642,544	22	
23			Radiology-Therapeutic	55		270,975	23	
24			Radioisotope	56		3,569	24	
25			Laboratory	60		674,594	25	
26			Blood Storing, Processing & T	63		23,430	26	
27			Respiratory Therapy	65		165,818	27	
28			Physical Therapy	66		3,615	28	
29			Electrocardiology	69		251,107	29	
30			Electroencephalography	70		86,777	30	
31			Renal Dialysis	74		24,712	31	
32			GI LAB	76		303,354	32	
33			MRI	76.01		432,666	33	
34			CT SCAN	76.02		147,451	34	
35			CARDIAC CATHETERIZATION	76.03		348,751	35	
36			SPECIAL SURGICAL SERVICES	76.08		22,309	36	
37			GENETIC SERVICES	76.10		62,144	37	
38			PAIN CENTER	90.01		65,811	38	
39			ANTENATAL TEST CENTER	90.02		29,583	39	
40			CHILD PSYCHIATRIC CLINIC	90.03		2,010	40	
41			Emergency	91		648,116	41	
42			Ambulance Services	95		8,913	42	
43			GUEST CENTER	194		6,329	43	
44			COMMUNITY SERVICES	194.02		5,520	44	
45			AUXILIARY	194.04		2,099	45	
500	Total reclassifications					15,158,779	500	
	Code letter - H							
1	INSURANCE RECLASS	I	Administrative & General	5		229,312	12	
2			Laboratory	60		633	2	
3			COMMUNITY SERVICES	194.02		1,343	3	
500	Total reclassifications					231,288	500	
	Code letter - I							
1	PASTORAL EDUCATION PROGRAM	J	Administrative & General	5	52,408	26,462	1	
500	Total reclassifications				52,408	26,462	500	
	Code letter - J							
1	IMPLANTS	K	Operating Room	50		11,575,345	1	
2			Radiology-Diagnostic	54		594,119	2	
3			CARDIAC CATHETERIZATION	76.03		3,474,885	3	
500	Total reclassifications					15,644,349	500	
	Code letter - K							
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4	952,775		1	
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5	7,323,281		2	
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7	154,162		3	
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16	135,978		4	
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17	60,050		5	
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02	254,565		6	
500	Total reclassifications				8,880,811		500	
	Code letter - L							
1	SHARED SERVICES DIRECT COST ASSIGNE	M	Administrative & General	5		2,081,009	1	
2	SHARED SERVICES DIRECT COST ASSIGNE	M	Operation of Plant	7		234,418	2	
3	SHARED SERVICES DIRECT COST ASSIGNE	M	Medical Records & Library	16		203,343	3	
4			Social Service	17		137,901	4	
5			Operating Room	50		39,672	5	
6			Radiology-Diagnostic	54		6,912	6	
7			Laboratory	60		18,540	7	
8			Respiratory Therapy	65		18,360	8	
9			Electrocardiology	69		49,500	9	
10			MRI	76.01		67,296	10	
11			CT SCAN	76.02		34,332	11	
12			SPECIAL SURGICAL SERVICES	76.08		52,884	12	
13			GENETIC SERVICES	76.10		55,380	13	
14			COMMUNITY SERVICES	194.02		1,323,032	14	
15			Electroencephalography	70		101,040	15	
500	Total reclassifications					4,423,619	500	
	Code letter - M							
	GRAND TOTAL (Decreases)				12,233,765	61,154,336		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	1,083,393					1,083,393		1
2	Land Improvements	8,706,379	151,945		151,945		8,858,324		2
3	Buildings and Fixtures	54,588,562	215,746		215,746		54,804,308		3
4	Building Improvements								4
5	Fixed Equipment	110,258,508	9,111,841		9,111,841		119,370,349		5
6	Movable Equipment	112,153,061	9,113,249		9,113,249	27,030,209	94,236,101		6
7	HIT-designated Assets	22,643,265	166,090		166,090		22,809,355		7
8	Subtotal (sum of lines 1-7)	309,433,168	18,758,871		18,758,871	27,030,209	301,161,830		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	309,433,168	18,758,871		18,758,871	27,030,209	301,161,830		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt								1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)								3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	184,116,374		184,116,374	0.611354					1
2	Cap Rel Costs-Mvble Equip	117,045,456		117,045,456	0.388646					2
3	Total (sum of lines 1-2)	301,161,830		301,161,830	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	-58,684			231,288			172,604	1	
2	Cap Rel Costs-Mvble Equip	15,152,111						15,152,111	2	
3	Total (sum of lines 1-2)	15,093,427			231,288			15,324,715	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trace, quantity, and time discounts (chapter 8)	B	-1,118	Central Services & Supply	14	4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)	A	-5,107	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-32,993,155			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	11,574,427			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-1,800,510	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts	B	-38,882	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33						33
33.01	XRAY COPY	B	-1,780	Radiology-Diagnostic	54	33.01
33.10	DAY CARE CENTER	B	-1,486,176	Employee Benefits Department	4	33.10
33.17	MISC REVENUE - CYTOGENETICS	B	-71,395	GENETIC SERVICES	76.10	33.17
33.83	PATIENT PHONES	A	-1,014	Cap Rel Costs-Bldg & Fixt	1	33.83
33.84	PATIENT PHONE COST	A	-6,668	Cap Rel Costs-Mvble Equip	2	33.84
33.85	PATIENT PHONES	A	-1,039	Employee Benefits Department	4	33.85
33.86	PATIENT PHONES	A	-111,455	Administrative & General	5	33.86
33.87	PATIENT PHONES	A	-170,344	Operation of Plant	7	33.87
33.88	PATIENT PHONES	A	-48,980	Housekeeping	9	33.88
33.89	AHA & IHA LOBBY EXPENSE	A	-19,455	Administrative & General	5	33.89
34	USEFUL LIFE CHG-SO MULFORD	A	-57,670	Cap Rel Costs-Bldg & Fixt	1	34
34.03	INTEREST EXPENSE	A	-1,358,546	Administrative & General	5	34.03
35	PHYSICIAN BILLING	A	-1,079	Administrative & General	5	35
36	REFERENCE LABORATORY	B	-8,874,056	Laboratory	60	36
37	PROVIDER TAX ASSESSMENT	A	-12,095,707	Administrative & General	5	37
38						38
39						39
40						40
41						41
42	MISC REVENUE	B	-25,590	Operation of Plant	7	42
43						43
44	PASTORAL CARE	B	-5,300	PASTORAL EDUCATION PROGRAM	23.01	44
45	EDUCATION REV	B	-31,202	PARAMDICAL ED PROGRAM XRAY	23	45
45.17	EMS REV	B	-106,071	PARAMED EDUC EMT PROGRAM	23.02	45.17
45.18	MISC REV	B	-14,125	NEONATAL INTENSIVE CARE	34.01	45.18
45.26	MISC REV	B	-220	Respiratory Therapy	65	45.26
45.42	MISC REV	B	-20	CHILD PSYCHIATRIC CLINIC	90.03	45.42
45.43	MISC REV	B	-35,805	Emergency	91	45.43
45.46	PROPERTY TAX	A	-118,854	GUEST CENTER	194	45.46
46	LEASE REVENUE	B	-33,850	Ambulance Services	95	46
47						47

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-47,940,746				50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.
	1	2	3	4	5	6	7
1	5	Administrative & General	NEW CAPITAL COSTS	1,794,844		1,794,844	1
2	50	Operating Room	MANAGEMENT FEES	43,704,001	33,924,418	9,779,583	2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			45,498,845	33,924,418	11,574,427	5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		Type of Business	
				Name	Percentage of Ownership		
	1	2	3	4	5	6	
6	E	RKFD MEM DVLMT			100.00	SERVICE	6
7	E	RMHSC				PHYSICIAN CLINI	7
8	E	FREEPOR MEM HO			50.00	MOBILE CATH LAB	8
9	B	ROCKFORD HEALTH SYSTEM				HOME OFFICE	9
10	B	VAN MATER REHAB HOSPITAL		VAN MATER REHAB HOSPITAL	50.00	REHAB HOSPITAL	10

(1) Use the following symbols to indicate the interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	4	Employee Benefits De PROFESSIONAL FE	3,407	3,407		171,400				1
2	5	Administrative & Gen PROFESSIONAL FE	31,911,143	29,302,600	2,608,543	171,400	63,400	5,224,404	261,220	2
3										3
4	13	Nursing Administrati PROFESSIONAL FE	141,440	53,840	87,600	204,100	120	11,775	589	4
5	17	Social Service PROFESSIONAL FE								5
6	30	Adults & Pediatrics PROFESSIONAL FE	76,428		76,428	154,100	324	24,004	1,200	6
7	31	Intensive Care Unit PROFESSIONAL FE	13,059		13,059	171,400	602	49,607	2,480	7
8	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE	71,520		71,520	171,400	345	28,429	1,421	8
9	34.02	PEDIATRIC INTENSIVE PROFESSIONAL FE	25,094		25,094	171,400	376	30,984	1,549	9
10	40	Subprovider - IPF PROFESSIONAL FE	37,700	37,700						10
11	50	Operating Room PROFESSIONAL FE	1,666,782		1,666,782	204,100	14,031	1,376,792	68,840	11
12										12
13	52	Delivery Room & Labo PROFESSIONAL FE	963,032		963,032	194,500	1,135	106,133	5,307	13
14	53	Anesthesiology PROFESSIONAL FE	1,657,316		1,657,316	200,300	496	47,764	2,388	14
15										15
16	60	Laboratory PROFESSIONAL FE	388,028	388,028						16
17	65	Respiratory Therapy PROFESSIONAL FE	34,339		34,339	194,500	183	17,112	856	17
18										18
19										19
20	76.03	CARDIAC CATHETERIZAT PROFESSIONAL FE	116,738	116,738						20
22	90.02	ANTENATAL TEST CENTE PROFESSIONAL FE	31,872	31,872		241,000	24	2,781	139	22
23	91	Emergency PROFESSIONAL FE	218,505		218,505	200,300	1,501	144,543	7,227	23
24	95	Ambulance Services PROFESSIONAL FE	40,000	40,000		194,500				24
200		TOTAL	37,396,403	29,974,185	7,422,218		82,537	7,064,328	353,216	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	4	Employee Benefits De	PROFESSIONAL FE						3,407	1
2	5	Administrative & Gen	PROFESSIONAL FE				5,224,404		29,302,600	2
3										3
4	13	Nursing Administrati	PROFESSIONAL FE				11,775	75,825	129,665	4
5	17	Social Service	PROFESSIONAL FE							5
6	30	Adults & Pediatrics	PROFESSIONAL FE				24,004	52,424	52,424	6
7	31	Intensive Care Unit	PROFESSIONAL FE				49,607			7
8	34.01	NEONATAL INTENSIVE C	PROFESSIONAL FE				28,429	43,091	43,091	8
9	34.02	PEDIATRIC INTENSIVE	PROFESSIONAL FE				30,984			9
10	40	Subprovider - IPF	PROFESSIONAL FE						37,700	10
11	50	Operating Room	PROFESSIONAL FE				1,376,792	289,990	289,990	11
12										12
13	52	Delivery Room & Labo	PROFESSIONAL FE				106,133	856,899	856,899	13
14	53	Anesthesiology	PROFESSIONAL FE				47,764	1,609,552	1,609,552	14
15										15
16	60	Laboratory	PROFESSIONAL FE						388,028	16
17	65	Respiratory Therapy	PROFESSIONAL FE				17,112	17,227	17,227	17
18										18
19										19
20	76.03	CARDIAC CATHETERIZAT	PROFESSIONAL FE						116,738	20
22	90.02	ANTENATAL TEST CENTE	PROFESSIONAL FE				2,781		31,872	22
23	91	Emergency	PROFESSIONAL FE				144,543	73,962	73,962	23
24	95	Ambulance Services	PROFESSIONAL FE						40,000	24
200		TOTAL					7,064,328	3,018,970	32,993,155	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	172,604	172,604					1
2	Cap Rel Costs-Mvble Equip	15,152,111		15,152,111				2
4	Employee Benefits Department	7,976,769	4,503	34,902	8,016,174			4
5	Administrative & General	58,639,910	48,051	6,334,130	898,615	65,920,706	65,920,706	5
6	Maintenance & Repairs							6
7	Operation of Plant	12,238,730	17,905	979,869	211,769	13,448,273	4,050,095	7
8	Laundry & Linen Service	1,023,014	924	6,925	8,201	1,039,064	312,926	8
9	Housekeeping	3,387,268	2,000	21,079	161,211	3,571,558	1,075,614	9
10	Dietary	1,685,295	2,476	59,887	1,807,741		544,421	10
11	Cafeteria	1,828,461	5,126		124,380	1,957,967	589,663	11
12	Maintenance of Personnel							12
13	Nursing Administration	4,446,050	1,396	21,091	283,184	4,751,721	1,431,033	13
14	Central Services & Supply	3,144,911	2,730	294,968	110,378	3,552,987	1,070,021	14
15	Pharmacy	5,424,965	1,574	206,693	316,926	5,950,158	1,791,956	15
16	Medical Records & Library	2,760,522	1,191	25,151	104,057	2,890,921	870,633	16
17	Social Service	370,269	448		21,770	392,487	118,202	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMEDICAL ED PROGRAM XRAY	164,633	142	80	12,647	177,502	53,457	23
23.01	PASTORAL EDUCATION PROGRAM	73,570	188		4,279	78,037	23,502	23.01
23.02	PARAMED EDUC EMT PROGRAM	643,099	1,218	8,396	31,705	684,418	206,120	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	27,932,320	24,972	1,253,437	1,612,302	30,823,031	9,282,785	30
31	Intensive Care Unit	7,430,824	2,113	230,805	324,114	7,987,856	2,405,631	31
34.01	NEONATAL INTENSIVE CARE	7,801,098	2,980	222,682	448,969	8,475,729	2,552,559	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,692,344	772	12,098	87,462	1,792,676	539,884	34.02
40	Subprovider - IPF	2,156,132	2,355	51,252	112,594	2,322,333	699,396	40
43	Nursery	2,764,964	1,413		145,093	2,911,470	876,821	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	24,857,750	10,366	1,202,234	581,533	26,651,883	8,026,508	50
51	Recovery Room	1,324,352	681	7,207	77,184	1,409,424	424,464	51
52	Delivery Room & Labor Room	3,861,548	2,969	236,385	204,549	4,305,451	1,296,634	52
53	Anesthesiology	1,900,413	196	188,246	28,005	2,116,860	637,516	53
54	Radiology-Diagnostic	4,109,578	2,737	562,245	211,822	4,886,382	1,471,588	54
55	Radiology-Therapeutic	1,469,571	2,838	239,647	74,230	1,786,286	537,960	55
56	Radioisotope	841,006	309	3,156	18,054	862,525	259,759	56
60	Laboratory	10,397,659	4,184	596,603	495,296	11,493,742	3,461,467	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,300,654	158	20,721	14,667	1,336,200	402,411	63
65	Respiratory Therapy	3,805,930	1,276	146,647	184,855	4,138,708	1,246,417	65
66	Physical Therapy	1,767,296	1,168	3,197	43,584	1,815,245	546,681	66
69	Electrocardiology	1,558,466	1,805	222,076	91,770	1,874,117	564,411	69
70	Electroencephalography	837,927	1,176	76,745	47,317	963,165	290,068	70
71	Medical Supplies Charged to Patients	10,378,625				10,378,625	3,125,637	71
72	Impl. Dev. Charged to Patients	15,644,349				15,644,349	4,711,468	72
73	Drugs Charged to Patients	12,167,825				12,167,825	3,664,474	73
74	Renal Dialysis	731,869	373	21,855		754,097	227,105	74
76	GI LAB	726,862	1,735	268,283	34,131	1,031,011	310,500	76
76.01	MRI	767,514	1,240	382,645	38,330	1,189,729	358,300	76.01
76.02	CT SCAN	1,047,433	628	130,404	53,413	1,231,878	370,994	76.02
76.03	CARDIAC CATHETERIZATION	1,509,968	1,182	308,431	74,580	1,894,161	570,447	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	398,655	751	19,730	18,189	437,325	131,705	76.08
76.10	GENETIC SERVICES	1,047,813	1,247	54,959	61,185	1,165,204	350,914	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	767,922	952	58,202	41,413	868,489	261,555	90.01
90.02	ANTENATAL TEST CENTER	587,793	1,146	26,163	28,663	643,765	193,877	90.02
90.03	CHILD PSYCHIATRIC CLINIC	420,342	361	1,778	26,514	448,995	135,220	90.03
91	Emergency	8,242,796	3,874	573,186	445,336	9,265,192	2,790,314	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	608,253	1,285	7,883	11,098	628,519	189,285	95

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	281,990,032	169,114	15,122,073	7,985,457	281,925,787	65,052,398	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,089,085				1,089,085	327,990	192
193.0 1	BELOIT HEART STANDBY	70,036			4,724	74,760	22,515	193.0 1
194	GUEST CENTER	245,164	1,123	5,597	5,644	257,528	77,557	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	906,488	113	22,584	10,569	939,754	283,017	194.0 2
194.0 4	AUXILIARY	508,185	2,254	1,857	9,780	522,076	157,229	194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	284,808,990	172,604	15,152,111	8,016,174	284,808,990	65,920,706	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	17,498,368						7
8	Laundry & Linen Service	158,321	1,510,311					8
9	Housekeeping	342,653	69	4,989,894				9
10	Dietary	424,181		124,526	2,900,869			10
11	Cafeteria	878,132		257,792		3,683,554		11
12	Maintenance of Personnel							12
13	Nursing Administration	239,098		70,191		83,654	6,575,697	13
14	Central Services & Supply	467,671	9,104	137,293		105,961		14
15	Pharmacy	269,694		79,174		128,269		15
16	Medical Records & Library	204,103		59,918		69,711		16
17	Social Service	76,792		22,544		11,154		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMDICAL ED PROGRAM XRAY	24,319		7,139		47,404		23
23.01	PASTORAL EDUCATION PROGRAM	32,288		9,479		33,462		23.01
23.02	PARAMED EDUC EMT PROGRAM	208,576		61,231		19,519	51,893	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	4,277,821	568,699	1,255,833	2,348,210	967,596	2,739,994	30
31	Intensive Care Unit	362,011	56,502	106,275	252,264	172,884	478,268	31
34.01	NEONATAL INTENSIVE CARE	510,521	41,310	149,873		228,654	775,303	34.01
34.02	PEDIATRIC INTENSIVE CARE	132,310	3,544	38,842	49,914	41,827	114,499	34.02
40	Subprovider - IPF	403,357	14,594	118,413	200,443	69,711		40
43	Nursery	242,067	9,454	71,063		72,500		43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,775,773	250,679	521,310		278,846	771,414	50
51	Recovery Room	116,636	13,479	34,241		33,462	94,437	51
52	Delivery Room & Labor Room	508,679	82,265	149,332		105,961	295,684	52
53	Anesthesiology	33,566		9,854		16,731	46,444	53
54	Radiology-Diagnostic	468,798	58,306	137,624		119,904		54
55	Radiology-Therapeutic	486,126	6,915	142,711		36,250		55
56	Radioisotope	52,962	14	15,548		8,365		56
60	Laboratory	716,804	16,405	210,431		340,192		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	27,063		7,945		8,365		63
65	Respiratory Therapy	218,537	291	64,155		128,269		65
66	Physical Therapy	200,044	811	58,726		19,519		66
69	Electrocardiology	309,275		90,793		50,192	135,424	69
70	Electroencephalography	201,434		59,135		27,885	75,275	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	63,862		18,748				74
76	GI LAB	297,209	19,075	87,251		19,519	51,682	76
76.01	MRI	212,373	13,127	62,346		22,308		76.01
76.02	CT SCAN	107,539		31,570		27,885		76.02
76.03	CARDIAC CATHETERIZATION	202,487	19,446	59,444		36,250	98,063	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	128,589	10,755	37,750		8,365	24,998	76.08
76.10	GENETIC SERVICES	213,575	252	62,699		27,885		76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	163,132		47,890		25,096	70,044	90.01
90.02	ANTENATAL TEST CENTER	196,398	11,061	57,656		13,942	39,582	90.02
90.03	CHILD PSYCHIATRIC CLINIC	61,870	371	18,163		8,365	26,791	90.03
91	Emergency	663,617	296,591	194,817	50,038	242,596	673,491	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	220,116	92	64,619		5,577	12,411	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	16,900,379	1,503,211	4,814,344	2,900,869	3,664,035	6,575,697	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER	192,376	7,100	56,475		2,788		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	19,433		5,705		5,577		194.02
194.04	AUXILIARY	386,180		113,370		11,154		194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,498,368	1,510,311	4,989,894	2,900,869	3,683,554	6,575,697	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION XRAY		
		14	15	16	17	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	5,343,037						14
15	Pharmacy		8,219,251					15
16	Medical Records & Library			4,095,286				16
17	Social Service				621,179			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMEDICAL ED PROGRAM XRAY					309,821		23
23.01	PASTORAL EDUCATION PROGRAM						176,768	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			247,942	529,047		111,821	30
31	Intensive Care Unit			64,850			13,458	31
34.01	NEONATAL INTENSIVE CARE			158,246	8,101		31,033	34.01
34.02	PEDIATRIC INTENSIVE CARE			15,922	2,303		2,663	34.02
40	Subprovider - IPF			21,188	77,201		10,694	40
43	Nursery			57,733	4,527		7,099	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			281,830				50
51	Recovery Room			34,480				51
52	Delivery Room & Labor Room			70,215				52
53	Anesthesiology		99,216	51,565				53
54	Radiology-Diagnostic			184,876		309,821		54
55	Radiology-Therapeutic			46,823				55
56	Radioisotope			36,705				56
60	Laboratory			281,580				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			48,748				63
65	Respiratory Therapy			115,919				65
66	Physical Therapy			28,461				66
69	Electrocardiology			118,216				69
70	Electroencephalography			38,746				70
71	Medical Supplies Charged to Patients	2,089,676		598,312				71
72	Impl. Dev. Charged to Patients	3,253,361		380,649				72
73	Drugs Charged to Patients		8,120,035	473,188				73
74	Renal Dialysis			6,697				74
76	GI LAB			27,395				76
76.01	MRI			101,675				76.01
76.02	CT SCAN			196,855				76.02
76.03	CARDIAC CATHETERIZATION			97,706				76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES			9,312				76.08
76.10	GENETIC SERVICES			3,167				76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER			33,773				90.01
90.02	ANTENATAL TEST CENTER			29,687				90.02
90.03	CHILD PSYCHIATRIC CLINIC			1,128				90.03
91	Emergency			228,262				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			3,271				95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDICA EDUCATION XRAY		
		14	15	16	17	23	23.01	
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,343,037	8,219,251	4,095,122	621,179	309,821	176,768	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER							194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES			164				194.0 2
194.0 4	AUXILIARY							194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,343,037	8,219,251	4,095,286	621,179	309,821	176,768	202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		23.02	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMDICAL ED PROGRAM XRAY						23
23.01	PASTORAL EDUCATION PROGRAM						23.01
23.02	PARAMED EDUC EMT PROGRAM	1,231,757					23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	32,719	53,185,498		53,185,498		30
31	Intensive Care Unit	65,437	11,965,436		11,965,436		31
34.01	NEONATAL INTENSIVE CARE		12,931,329		12,931,329		34.01
34.02	PEDIATRIC INTENSIVE CARE		2,734,384		2,734,384		34.02
40	Subprovider - IPF		3,937,330		3,937,330		40
43	Nursery		4,252,734		4,252,734		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	171,291	38,729,534		38,729,534		50
51	Recovery Room		2,160,623		2,160,623		51
52	Delivery Room & Labor Room	32,719	6,846,940		6,846,940		52
53	Anesthesiology		3,011,752		3,011,752		53
54	Radiology-Diagnostic		7,637,299		7,637,299		54
55	Radiology-Therapeutic		3,043,071		3,043,071		55
56	Radioisotope		1,235,878		1,235,878		56
60	Laboratory		16,520,621		16,520,621		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		1,830,732		1,830,732		63
65	Respiratory Therapy	25,020	5,937,316		5,937,316		65
66	Physical Therapy		2,669,487		2,669,487		66
69	Electrocardiology		3,142,428		3,142,428		69
70	Electroencephalography		1,655,708		1,655,708		70
71	Medical Supplies Charged to Patients		16,192,250		16,192,250		71
72	Impl. Dev. Charged to Patients		23,989,827		23,989,827		72
73	Drugs Charged to Patients		24,425,522		24,425,522		73
74	Renal Dialysis		1,070,509		1,070,509		74
76	GI LAB		1,843,642		1,843,642		76
76.01	MRI		1,959,858		1,959,858		76.01
76.02	CT SCAN		1,966,721		1,966,721		76.02
76.03	CARDIAC CATHETERIZATION		2,978,004		2,978,004		76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES		788,799		788,799		76.08
76.10	GENETIC SERVICES		1,823,696		1,823,696		76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER		1,469,979		1,469,979		90.01
90.02	ANTENATAL TEST CENTER		1,185,968		1,185,968		90.02
90.03	CHILD PSYCHIATRIC CLINIC		700,903		700,903		90.03
91	Emergency	904,571	15,309,489		15,309,489		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services		1,123,890		1,123,890		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		23.02	24	25	26		
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	1,231,757	280,257,157		280,257,157		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		1,417,075		1,417,075		192
193.0 1	BELOIT HEART STANDBY		97,275		97,275		193.0 1
194	GUEST CENTER		593,824		593,824		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER						194.0 1
194.0 2	COMMUNITY SERVICES		1,253,650		1,253,650		194.0 2
194.0 4	AUXILIARY		1,190,009		1,190,009		194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM						194.0 7
194.0 8	DIALYSIS RENTED SPACE						194.0 8
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,231,757	284,808,990		284,808,990		202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	19,043	4,503	34,902	58,448	58,448		4
5	Administrative & General	115,387	48,051	6,334,130	6,497,568	6,549	6,504,117	5
6	Maintenance & Repairs							6
7	Operation of Plant	9,914	17,905	979,869	1,007,688	1,543	399,602	7
8	Laundry & Linen Service		924	6,925	7,849	60	30,875	8
9	Housekeeping	13,856	2,000	21,079	36,935	1,175	106,125	9
10	Dietary	4,337	2,476	59,887	66,700	438	53,715	10
11	Cafeteria		5,126		5,126	906	58,179	11
12	Maintenance of Personnel							12
13	Nursing Administration	18,224	1,396	21,091	40,711	2,064	141,193	13
14	Central Services & Supply	57,189	2,730	294,968	354,887	804	105,573	14
15	Pharmacy	16,512	1,574	206,693	224,779	2,310	176,803	15
16	Medical Records & Library	21,828	1,191	25,151	48,170	758	85,901	16
17	Social Service		448		448	159	11,662	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMDICAL ED PROGRAM XRAY	7,239	142	80	7,461	92	5,274	23
23.01	PASTORAL EDUCATION PROGRAM		188		188	31	2,319	23.01
23.02	PARAMED EDUC EMT PROGRAM	15,899	1,218	8,396	25,513	231	20,337	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	111,015	24,972	1,253,437	1,389,424	11,778	915,947	30
31	Intensive Care Unit	11,377	2,113	230,805	244,295	2,362	237,351	31
34.01	NEONATAL INTENSIVE CARE	31,170	2,980	222,682	256,832	3,272	251,848	34.01
34.02	PEDIATRIC INTENSIVE CARE	9,212	772	12,098	22,082	637	53,268	34.02
40	Subprovider - IPF	10,744	2,355	51,252	64,351	821	69,006	40
43	Nursery		1,413		1,413	1,057	86,511	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	285,105	10,366	1,202,234	1,497,705	4,238	791,934	50
51	Recovery Room	724	681	7,207	8,612	562	41,880	51
52	Delivery Room & Labor Room	12,572	2,969	236,385	251,926	1,491	127,932	52
53	Anesthesiology	23,548	196	188,246	211,990	204	62,900	53
54	Radiology-Diagnostic	18,747	2,737	562,245	583,729	1,544	145,194	54
55	Radiology-Therapeutic	6,824	2,838	239,647	249,309	541	53,078	55
56	Radioisotope	185	309	3,156	3,650	132	25,629	56
60	Laboratory	37,554	4,184	596,603	638,341	3,610	341,525	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,947	158	20,721	22,826	107	39,704	63
65	Respiratory Therapy	18,823	1,276	146,647	166,746	1,347	122,978	65
66	Physical Therapy	7,706	1,168	3,197	12,071	318	53,938	66
69	Electrocardiology	8,009	1,805	222,076	231,890	669	55,688	69
70	Electroencephalography		1,176	76,745	77,921	345	28,619	70
71	Medical Supplies Charged to Patients						308,390	71
72	Impl. Dev. Charged to Patients						464,856	72
73	Drugs Charged to Patients						361,555	73
74	Renal Dialysis		373	21,855	22,228		22,407	74
76	GI LAB	1,989	1,735	268,283	272,007	249	30,635	76
76.01	MRI	524	1,240	382,645	384,409	279	35,352	76.01
76.02	CT SCAN	1,067	628	130,404	132,099	389	36,604	76.02
76.03	CARDIAC CATHETERIZATION	13,601	1,182	308,431	323,214	544	56,283	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	3,475	751	19,730	23,956	133	12,995	76.08
76.10	GENETIC SERVICES	2,783	1,247	54,959	58,989	446	34,623	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	13,317	952	58,202	72,471	302	25,806	90.01
90.02	ANTENATAL TEST CENTER	8,422	1,146	26,163	35,731	209	19,129	90.02
90.03	CHILD PSYCHIATRIC CLINIC	1,099	361	1,778	3,238	193	13,341	90.03
91	Emergency	22,618	3,874	573,186	599,678	3,245	275,306	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	585	1,285	7,883	9,753	81	18,676	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	964,170	169,114	15,122,073	16,255,357	58,225	6,418,446	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	340			340		32,361	192
193.0 1	BELOIT HEART STANDBY					34	2,221	193.0 1
194	GUEST CENTER		1,123	5,597	6,720	41	7,652	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	162	113	22,584	22,859	77	27,924	194.0 2
194.0 4	AUXILIARY	1,596	2,254	1,857	5,707	71	15,513	194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	966,268	172,604	15,152,111	16,290,983	58,448	6,504,117	202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,408,833						7
8	Laundry & Linen Service	12,747	51,531					8
9	Housekeeping	27,588	2	171,825				9
10	Dietary	34,152		4,288	159,293			10
11	Cafeteria	70,700		8,877		143,788		11
12	Maintenance of Personnel							12
13	Nursing Administration	19,250		2,417		3,265	208,900	13
14	Central Services & Supply	37,653	311	4,728		4,136		14
15	Pharmacy	21,714		2,726		5,007		15
16	Medical Records & Library	16,433		2,063		2,721		16
17	Social Service	6,183		776		435		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMDICAL ED PROGRAM XRAY	1,958		246		1,850		23
23.01	PASTORAL EDUCATION PROGRAM	2,600		326		1,306		23.01
23.02	PARAMED EDUC EMT PROGRAM	16,793		2,108		762	1,649	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	344,417	19,403	43,247	128,945	37,771	87,048	30
31	Intensive Care Unit	29,146	1,928	3,660	13,852	6,749	15,194	31
34.01	NEONATAL INTENSIVE CARE	41,103	1,409	5,161		8,926	24,630	34.01
34.02	PEDIATRIC INTENSIVE CARE	10,653	121	1,338	2,741	1,633	3,637	34.02
40	Subprovider - IPF	32,475	498	4,078	11,007	2,721		40
43	Nursery	19,489	323	2,447		2,830		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	142,971	8,553	17,951		10,885	24,507	50
51	Recovery Room	9,391	460	1,179		1,306	3,000	51
52	Delivery Room & Labor Room	40,955	2,807	5,142		4,136	9,393	52
53	Anesthesiology	2,702		339		653	1,475	53
54	Radiology-Diagnostic	37,744	1,989	4,739		4,680		54
55	Radiology-Therapeutic	39,139	236	4,914		1,415		55
56	Radioisotope	4,264		535		327		56
60	Laboratory	57,712	560	7,246		13,279		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	2,179		274		327		63
65	Respiratory Therapy	17,595	10	2,209		5,007		65
66	Physical Therapy	16,106	28	2,022		762		66
69	Electrocardiology	24,900		3,126		1,959	4,302	69
70	Electroencephalography	16,218		2,036		1,088	2,391	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	5,142		646				74
76	GI LAB	23,929	651	3,004		762	1,642	76
76.01	MRI	17,099	448	2,147		871		76.01
76.02	CT SCAN	8,658		1,087		1,088		76.02
76.03	CARDIAC CATHETERIZATION	16,303	663	2,047		1,415	3,115	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	10,353	367	1,300		327	794	76.08
76.10	GENETIC SERVICES	17,195	9	2,159		1,088		76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	13,134		1,649		980	2,225	90.01
90.02	ANTENATAL TEST CENTER	15,812	377	1,985		544	1,257	90.02
90.03	CHILD PSYCHIATRIC CLINIC	4,981	13	625		327	851	90.03
91	Emergency	53,429	10,120	6,708	2,748	9,470	21,396	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	17,722	3	2,225		218	394	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,360,687	51,289	165,780	159,293	143,026	208,900	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER	15,489	242	1,945		109		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	1,565		196		218		194.0 2
194.0 4	AUXILIARY	31,092		3,904		435		194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,408,833	51,531	171,825	159,293	143,788	208,900	202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION XRAY		
		14	15	16	17	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	508,092						14
15	Pharmacy		433,339					15
16	Medical Records & Library			156,046				16
17	Social Service				19,663			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMEDICAL ED PROGRAM XRAY					16,881		23
23.01	PASTORAL EDUCATION PROGRAM						6,770	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			9,455	16,747			30
31	Intensive Care Unit			2,473				31
34.01	NEONATAL INTENSIVE CARE			6,035	256			34.01
34.02	PEDIATRIC INTENSIVE CARE			607	73			34.02
40	Subprovider - IPF			808	2,444			40
43	Nursery			2,202	143			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			10,748				50
51	Recovery Room			1,315				51
52	Delivery Room & Labor Room			2,678				52
53	Anesthesiology		5,231	1,966				53
54	Radiology-Diagnostic			7,050				54
55	Radiology-Therapeutic			1,786				55
56	Radioisotope			1,400				56
60	Laboratory			10,738				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			1,859				63
65	Respiratory Therapy			4,421				65
66	Physical Therapy			1,085				66
69	Electrocardiology			4,508				69
70	Electroencephalography			1,478				70
71	Medical Supplies Charged to Patients	198,720		22,688				71
72	Impl. Dev. Charged to Patients	309,372		14,516				72
73	Drugs Charged to Patients		428,108	18,045				73
74	Renal Dialysis			255				74
76	GI LAB			1,045				76
76.01	MRI			3,877				76.01
76.02	CT SCAN			7,507				76.02
76.03	CARDIAC CATHETERIZATION			3,726				76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES			355				76.10
76.11	CARDIOLOGY			121				76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER			1,288				90.01
90.02	ANTENATAL TEST CENTER			1,132				90.02
90.03	CHILD PSYCHIATRIC CLINIC			43				90.03
91	Emergency			8,705				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			125				95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDICA EDUCATION XRAY		
		14	15	16	17	23	23.01	
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	508,092	433,339	156,040	19,663			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER							194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES			6				194.0 2
194.0 4	AUXILIARY							194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments					16,881	6,770	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	508,092	433,339	156,046	19,663	16,881	6,770	202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		23.02	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMDICAL ED PROGRAM XRAY						23
23.01	PASTORAL EDUCATION PROGRAM						23.01
23.02	PARAMED EDUC EMT PROGRAM	67.393					23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		3,004,182		3,004,182		30
31	Intensive Care Unit		557,010		557,010		31
34.01	NEONATAL INTENSIVE CARE		599,472		599,472		34.01
34.02	PEDIATRIC INTENSIVE CARE		96,790		96,790		34.02
40	Subprovider - IPF		188,209		188,209		40
43	Nursery		116,415		116,415		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		2,509,492		2,509,492		50
51	Recovery Room		67,705		67,705		51
52	Delivery Room & Labor Room		446,460		446,460		52
53	Anesthesiology		287,460		287,460		53
54	Radiology-Diagnostic		786,669		786,669		54
55	Radiology-Therapeutic		350,418		350,418		55
56	Radioisotope		35,937		35,937		56
60	Laboratory		1,073,011		1,073,011		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		67,276		67,276		63
65	Respiratory Therapy		320,313		320,313		65
66	Physical Therapy		86,330		86,330		66
69	Electrocardiology		327,042		327,042		69
70	Electroencephalography		130,096		130,096		70
71	Medical Supplies Charged to Patients		529,798		529,798		71
72	Impl. Dev. Charged to Patients		788,744		788,744		72
73	Drugs Charged to Patients		807,708		807,708		73
74	Renal Dialysis		50,678		50,678		74
76	GI LAB		333,924		333,924		76
76.01	MRI		444,482		444,482		76.01
76.02	CT SCAN		187,432		187,432		76.02
76.03	CARDIAC CATHETERIZATION		407,310		407,310		76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES		50,580		50,580		76.08
76.10	GENETIC SERVICES		114,630		114,630		76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER		117,855		117,855		90.01
90.02	ANTENATAL TEST CENTER		76,176		76,176		90.02
90.03	CHILD PSYCHIATRIC CLINIC		23,612		23,612		90.03
91	Emergency		990,805		990,805		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services		49,197		49,197		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		23.02	24	25	26		
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		16,023,218		16,023,218		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		32,701		32,701		192
193.0 1	BELOIT HEART STANDBY		2,255		2,255		193.0 1
194	GUEST CENTER		32,198		32,198		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER						194.0 1
194.0 2	COMMUNITY SERVICES		52,845		52,845		194.0 2
194.0 4	AUXILIARY		56,722		56,722		194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM						194.0 7
194.0 8	DIALYSIS RENTED SPACE						194.0 8
200	Cross Foot Adjustments	67,393	91,044		91,044		200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	67,393	16,290,983		16,290,983		202

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	786,632						1
2	Cap Rel Costs-Mvble Equip		17,132,869					2
4	Employee Benefits Department	20,522	39,465	98,183,300				4
5	Administrative & General	218,981	7,162,153	11,006,370	-65,920,706	218,888,284		5
6	Maintenance & Repairs							6
7	Operation of Plant	81,599	1,107,963	2,593,779		13,448,273	465,530	7
8	Laundry & Linen Service	4,212	7,830	100,449		1,039,064	4,212	8
9	Housekeeping	9,116	23,835	1,974,532		3,571,558	9,116	9
10	Dietary	11,285	67,716	735,908		1,807,741	11,285	10
11	Cafeteria	23,362		1,523,429		1,957,967	23,362	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,361	23,848	3,468,484		4,751,721	6,361	13
14	Central Services & Supply	12,442	333,528	1,351,928		3,552,987	12,442	14
15	Pharmacy	7,175	233,713	3,881,754		5,950,158	7,175	15
16	Medical Records & Library	5,430	28,439	1,274,508		2,890,921	5,430	16
17	Social Service	2,043		266,645		392,487	2,043	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMDICAL ED PROGRAM XRAY	647	90	154,901		177,502	647	23
23.01	PASTORAL EDUCATION PROGRAM	859		52,408		78,037	859	23.01
23.02	PARAMED EDUC EMT PROGRAM	5,549	9,494	388,328		684,418	5,549	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,808	1,417,293	19,747,700		30,823,031	113,808	30
31	Intensive Care Unit	9,631	260,977	3,969,795		7,987,856	9,631	31
34.01	NEONATAL INTENSIVE CARE	13,582	251,792	5,499,042		8,475,729	13,582	34.01
34.02	PEDIATRIC INTENSIVE CARE	3,520	13,679	1,071,242		1,792,676	3,520	34.02
40	Subprovider - IPF	10,731	57,952	1,379,072		2,322,333	10,731	40
43	Nursery	6,440		1,777,117		2,911,470	6,440	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,243	1,359,396	7,122,696		26,651,883	47,243	50
51	Recovery Room	3,103	8,149	945,364		1,409,424	3,103	51
52	Delivery Room & Labor Room	13,533	267,287	2,505,349		4,305,451	13,533	52
53	Anesthesiology	893	212,855	343,009		2,116,860	893	53
54	Radiology-Diagnostic	12,472	635,745	2,594,431		4,886,382	12,472	54
55	Radiology-Therapeutic	12,933	270,975	909,178		1,786,286	12,933	55
56	Radioisotope	1,409	3,569	221,134		862,525	1,409	56
60	Laboratory	19,070	674,594	6,066,460		11,493,742	19,070	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	720	23,430	179,641		1,336,200	720	63
65	Respiratory Therapy	5,814	165,818	2,264,136		4,138,708	5,814	65
66	Physical Therapy	5,322	3,615	533,826		1,815,245	5,322	66
69	Electrocardiology	8,228	251,107	1,124,008		1,874,117	8,228	69
70	Electroencephalography	5,359	86,777	579,544		963,165	5,359	70
71	Medical Supplies Charged to Patients					10,378,625		71
72	Impl. Dev. Charged to Patients					15,644,349		72
73	Drugs Charged to Patients					12,167,825		73
74	Renal Dialysis	1,699	24,712			754,097	1,699	74
76	GI LAB	7,907	303,354	418,045		1,031,011	7,907	76
76.01	MRI	5,650	432,666	469,467		1,189,729	5,650	76.01
76.02	CT SCAN	2,861	147,451	654,213		1,231,878	2,861	76.02
76.03	CARDIAC CATHETERIZATION	5,387	348,751	913,464		1,894,161	5,387	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	3,421	22,309	222,787		437,325	3,421	76.08
76.10	GENETIC SERVICES	5,682	62,144	749,404		1,165,204	5,682	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	4,340	65,811	507,237		868,489	4,340	90.01
90.02	ANTENATAL TEST CENTER	5,225	29,583	351,071		643,765	5,225	90.02
90.03	CHILD PSYCHIATRIC CLINIC	1,646	2,010	324,748		448,995	1,646	90.03
91	Emergency	17,655	648,116	5,454,539		9,265,192	17,655	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	5,856	8,913	135,926		628,519	5,856	95
99.10	CORF							99.10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	770,723	17,098,904	97,807,068	-65,920,706	216,005,081	449,621	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices					1,089,085		192
193.0 1	BELOIT HEART STANDBY			57,857		74,760		193.0 1
194	GUEST CENTER	5,118	6,329	69,131		257,528	5,118	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	517	25,536	129,455		939,754	517	194.0 2
194.0 4	AUXILIARY	10,274	2,100	119,789		522,076	10,274	194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	172,604	15,152,111	8,016,174		65,920,706	17,498,368	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.219422	0.884388	0.081645		0.301161	37.588057	203
204	Cost to be allocated (Per Wkst. B, Part II)			58,448		6,504,117	1,408,833	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000595		0.029714	3.026299	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	659,623						8
9	Housekeeping	30	452,202					9
10	Dietary		11,285	209,863				10
11	Cafeteria		23,362		1,321			11
12	Maintenance of Personnel							12
13	Nursing Administration		6,361		30	1,782,404		13
14	Central Services & Supply	3,976	12,442		38		25,692,898	14
15	Pharmacy		7,175		46			15
16	Medical Records & Library		5,430		25			16
17	Social Service		2,043		4			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMEDICAL ED PROGRAM XRAY		647		17			23
23.01	PASTORAL EDUCATION PROGRAM		859		12			23.01
23.02	PARAMED EDUC EMT PROGRAM		5,549		7	14,066		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	248,378	113,808	169,881	347	742,701		30
31	Intensive Care Unit	24,677	9,631	18,250	62	129,639		31
34.01	NEONATAL INTENSIVE CARE	18,042	13,582		82	210,153		34.01
34.02	PEDIATRIC INTENSIVE CARE	1,548	3,520	3,611	15	31,036		34.02
40	Subprovider - IPF	6,374	10,731	14,501	25			40
43	Nursery	4,129	6,440		26			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	109,483	47,243		100	209,099		50
51	Recovery Room	5,887	3,103		12	25,598		51
52	Delivery Room & Labor Room	35,929	13,533		38	80,148		52
53	Anesthesiology		893		6	12,589		53
54	Radiology-Diagnostic	25,465	12,472		43			54
55	Radiology-Therapeutic	3,020	12,933		13			55
56	Radioisotope	6	1,409		3			56
60	Laboratory	7,165	19,070		122			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		720		3			63
65	Respiratory Therapy	127	5,814		46			65
66	Physical Therapy	354	5,322		7			66
69	Electrocardiology		8,228		18	36,708		69
70	Electroencephalography		5,359		10	20,404		70
71	Medical Supplies Charged to Patients						10,048,549	71
72	Impl. Dev. Charged to Patients						15,644,349	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		1,699					74
76	GI LAB	8,331	7,907		7	14,009		76
76.01	MRI	5,733	5,650		8			76.01
76.02	CT SCAN		2,861		10			76.02
76.03	CARDIAC CATHETERIZATION	8,493	5,387		13	26,581		76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	4,697	3,421		3	6,776		76.08
76.10	GENETIC SERVICES	110	5,682		10			76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		4,340		9	18,986		90.01
90.02	ANTENATAL TEST CENTER	4,831	5,225		5	10,729		90.02
90.03	CHILD PSYCHIATRIC CLINIC	162	1,646		3	7,262		90.03
91	Emergency	129,535	17,655	3,620	87	182,556		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	40	5,856		2	3,364		95
99.10	CORF							99.10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	656,522	436,293	209,863	1,314	1,782,404	25,692,898	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0	BELOIT HEART STANDBY							193.0
1								1
194	GUEST CENTER	3,101	5,118		1			194
194.0	OTHER NONREIMBURSEABLE COST CENTER							194.0
1								1
194.0	COMMUNITY SERVICES		517		2			194.0
2								2
194.0	AUXILIARY		10,274		4			194.0
4								4
194.0	ROCKFORD HEALTH SYSTEM							194.0
7								7
194.0	DIALYSIS RENTED SPACE							194.0
8								8
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,510,311	4,989,894	2,900,869	3,683,554	6,575,697	5,343,037	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.289658	11.034657	13.822680	2.788.458743	3.689229	0.207958	203
204	Cost to be allocated (Per Wkst. B, Part II)	51,531	171,825	159,293	143,788	208,900	508,092	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.078122	0.379974	0.759033	108.847843	0.117201	0.019776	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE VISITS	PARAMEDICA EDUCATION XRAY ASSIGNED TIME		PARA MED EDUC EMT TIME SPENT	
	15	16	17	23	23.01	23.02	

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	12,316,499					15
16	Medical Records & Library		964,150,025				16
17	Social Service			7,821			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMDICAL ED PROGRAM XRAY				100		23
23.01	PASTORAL EDUCATION PROGRAM					68,103	23.01
23.02	PARAMED EDUC EMT PROGRAM						640
							23.02
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		58,366,762	6,661		43,081	17
31	Intensive Care Unit		15,265,939			5,185	34
34.01	NEONATAL INTENSIVE CARE		37,251,954	102		11,956	34.01
34.02	PEDIATRIC INTENSIVE CARE		3,748,068	29		1,026	34.02
40	Subprovider - IPF		4,987,652	972		4,120	40
43	Nursery		13,590,718	57		2,735	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		66,344,211				89
51	Recovery Room		8,116,736				51
52	Delivery Room & Labor Room		16,529,065				17
53	Anesthesiology	148,674	12,138,588				53
54	Radiology-Diagnostic		43,520,615		100		54
55	Radiology-Therapeutic		11,022,414				55
56	Radioisotope		8,640,421				56
60	Laboratory		66,285,345				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		11,475,457				63
65	Respiratory Therapy		27,288,013				13
66	Physical Therapy		6,699,922				66
69	Electrocardiology		27,828,572				69
70	Electroencephalography		9,120,892				70
71	Medical Supplies Charged to Patients		140,945,400				71
72	Impl. Dev. Charged to Patients		89,606,678				72
73	Drugs Charged to Patients	12,167,825	111,390,828				73
74	Renal Dialysis		1,576,498				74
76	GI LAB		6,449,034				76
76.01	MRI		23,934,684				76.01
76.02	CT SCAN		46,340,535				76.02
76.03	CARDIAC CATHETERIZATION		23,000,451				76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES		2,191,983				76.08
76.10	GENETIC SERVICES		745,520				76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		7,950,438				90.01
90.02	ANTENATAL TEST CENTER		6,988,372				90.02
90.03	CHILD PSYCHIATRIC CLINIC		265,648				90.03
91	Emergency		53,733,970				470
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE VISITS	PARAMEDICA EDUCATION XRAY ASSIGNED TIME		PARA MED EDUC EMT TIME SPENT	
		15	16	17	23	23.01	23.02	
95	Ambulance Services		769,985					95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	12,316,499	964,111,368	7,821	100	68,103	640	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER							194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES		38,657					194.0 2
194.0 4	AUXILIARY							194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	8,219,251	4,095,286	621,179	309,821	176,768	1,231,757	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.667337	0.004248	79.424498	3,098.210000	2.595598	1,924.620313	203
204	Cost to be allocated (Per Wkst. B, Part II)	433,339	156,046	19,663	16,881	6,770	67,393	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.035184	0.000162	2.514129	168.810000	0.099408	105.301563	205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	53,185,498		53,185,498	52,424	53,237,922	30
31	Intensive Care Unit	11,965,436		11,965,436		11,965,436	31
34.01	NEONATAL INTENSIVE CARE	12,931,329		12,931,329	43,091	12,974,420	34.01
34.02	PEDIATRIC INTENSIVE CARE	2,734,384		2,734,384		2,734,384	34.02
40	Subprovider - IPF	3,937,330		3,937,330		3,937,330	40
43	Nursery	4,252,734		4,252,734		4,252,734	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	38,729,534		38,729,534	289,990	39,019,524	50
51	Recovery Room	2,160,623		2,160,623		2,160,623	51
52	Delivery Room & Labor Room	6,846,940		6,846,940	856,899	7,703,839	52
53	Anesthesiology	3,011,752		3,011,752	1,609,552	4,621,304	53
54	Radiology-Diagnostic	7,637,299		7,637,299		7,637,299	54
55	Radiology-Therapeutic	3,043,071		3,043,071		3,043,071	55
56	Radioisotope	1,235,878		1,235,878		1,235,878	56
60	Laboratory	16,520,621		16,520,621		16,520,621	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	1,830,732		1,830,732		1,830,732	63
65	Respiratory Therapy	5,937,316		5,937,316	17,227	5,954,543	65
66	Physical Therapy	2,669,487		2,669,487		2,669,487	66
69	Electrocardiology	3,142,428		3,142,428		3,142,428	69
70	Electroencephalography	1,655,708		1,655,708		1,655,708	70
71	Medical Supplies Charged to Patients	16,192,250		16,192,250		16,192,250	71
72	Impl. Dev. Charged to Patients	23,989,827		23,989,827		23,989,827	72
73	Drugs Charged to Patients	24,425,522		24,425,522		24,425,522	73
74	Renal Dialysis	1,070,509		1,070,509		1,070,509	74
76	GI LAB	1,843,642		1,843,642		1,843,642	76
76.01	MRI	1,959,858		1,959,858		1,959,858	76.01
76.02	CT SCAN	1,966,721		1,966,721		1,966,721	76.02
76.03	CARDIAC CATHETERIZATION	2,978,004		2,978,004		2,978,004	76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	788,799		788,799		788,799	76.08
76.10	GENETIC SERVICES	1,823,696		1,823,696		1,823,696	76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	1,469,979		1,469,979		1,469,979	90.01
90.02	ANTENATAL TEST CENTER	1,185,968		1,185,968		1,185,968	90.02
90.03	CHILD PSYCHIATRIC CLINIC	700,903		700,903		700,903	90.03
91	Emergency	15,309,489		15,309,489	73,962	15,383,451	91
92	Observation Beds (Non-Distinct Part)	5,230,759		5,230,759		5,230,759	92
OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,123,890		1,123,890		1,123,890	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	285,487,916		285,487,916	2,943,145	288,431,061	200
201	Less Observation Beds	5,230,759		5,230,759		5,230,759	201
202	Total (line 200 minus line 201)	280,257,157		280,257,157		283,200,302	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	40,502,001		40,502,001				30
31	Intensive Care Unit	15,203,996		15,203,996				31
34.01	NEONATAL INTENSIVE CARE	37,252,031		37,252,031				34.01
34.02	PEDIATRIC INTENSIVE CARE	3,668,081		3,668,081				34.02
40	Subprovider - IPF	4,987,652		4,987,652				40
43	Nursery	13,417,409		13,417,409				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,144,980	31,199,231	66,344,211	0.583767	0.583767	0.588138	50
51	Recovery Room	4,390,652	3,726,084	8,116,736	0.266194	0.266194	0.266194	51
52	Delivery Room & Labor Room	13,496,808	3,032,256	16,529,064	0.414236	0.414236	0.466078	52
53	Anesthesiology	6,510,811	5,627,777	12,138,588	0.248114	0.248114	0.380712	53
54	Radiology-Diagnostic	21,231,689	22,288,925	43,520,614	0.175487	0.175487	0.175487	54
55	Radiology-Therapeutic	331,813	10,690,602	11,022,415	0.276080	0.276080	0.276080	55
56	Radioisotope	1,614,820	7,025,601	8,640,421	0.143034	0.143034	0.143034	56
60	Laboratory	43,250,988	23,034,357	66,285,345	0.249235	0.249235	0.249235	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	9,712,245	1,763,212	11,475,457	0.159535	0.159535	0.159535	63
65	Respiratory Therapy	25,666,668	1,621,346	27,288,014	0.217580	0.217580	0.218211	65
66	Physical Therapy	5,031,250	1,668,672	6,699,922	0.398436	0.398436	0.398436	66
69	Electrocardiology	9,990,516	17,838,056	27,828,572	0.112921	0.112921	0.112921	69
70	Electroencephalography	1,323,473	7,797,419	9,120,892	0.181529	0.181529	0.181529	70
71	Medical Supplies Charged to Patients	98,351,977	42,593,423	140,945,400	0.114883	0.114883	0.114883	71
72	Impl. Dev. Charged to Patients	63,265,536	26,341,142	89,606,678	0.267724	0.267724	0.267724	72
73	Drugs Charged to Patients	64,195,734	47,195,095	111,390,829	0.219278	0.219278	0.219278	73
74	Renal Dialysis	1,481,633	94,865	1,576,498	0.679042	0.679042	0.679042	74
76	GI LAB	1,887,888	4,561,146	6,449,034	0.285879	0.285879	0.285879	76
76.01	MRI	5,902,335	18,032,349	23,934,684	0.081884	0.081884	0.081884	76.01
76.02	CT SCAN	17,791,434	28,549,101	46,340,535	0.042441	0.042441	0.042441	76.02
76.03	CARDIAC CATHETERIZATION	10,496,930	12,503,521	23,000,451	0.129476	0.129476	0.129476	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	24,712	2,167,272	2,191,984	0.359856	0.359856	0.359856	76.08
76.10	GENETIC SERVICES	99,934	645,586	745,520	2.446207	2.446207	2.446207	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	122,855	7,827,583	7,950,438	0.184893	0.184893	0.184893	90.01
90.02	ANTENATAL TEST CENTER	363,622	6,624,750	6,988,372	0.169706	0.169706	0.169706	90.02
90.03	CHILD PSYCHIATRIC CLINIC		265,648	265,648	2.638465	2.638465	2.638465	90.03
91	Emergency	16,198,293	37,535,678	53,733,971	0.284913	0.284913	0.286289	91
92	Observation Beds (Non-Distinct Part)		18,006,614	18,006,614	0.290491	0.290491	0.290491	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	607,010	162,975	769,985	1.459626	1.459626	1.459626	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	573,517,776	390,420,286	963,938,062				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	573,517,776	390,420,286	963,938,062				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,004,182		3,004,182	47,775	62.88	18,562	1,167,179	30
31	Intensive Care Unit	557,010		557,010	5,185	107.43	2,133	229,148	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	599,472		599,472	11,956	50.14			34.01
34.02	PEDIATRIC INTENSIVE CARE	96,790		96,790	1,026	94.34			34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	188,209		188,209	4,120	45.68	995	45,452	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	116,415		116,415	2,735	42.56			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,562,078		4,562,078	72,797		21,690	1,441,779	200

(A) Worksheet A line numbers

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART II

Check [] Title V [XX] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] TEFRA
 Boxes: [] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5			
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,509,492	66,344,211	0.037825	14,142,960	534,957	50
51	Recovery Room	67,705	8,116,736	0.008341	1,654,273	13,798	51
52	Delivery Room & Labor Room	446,460	16,529,064	0.027011	11,728	317	52
53	Anesthesiology	287,460	12,138,588	0.023682	2,016,720	47,760	53
54	Radiology-Diagnostic	786,669	43,520,614	0.018076	7,218,865	130,488	54
55	Radiology-Therapeutic	350,418	11,022,415	0.031791	95,986	3,051	55
56	Radioisotope	35,937	8,640,421	0.004159	882,342	3,670	56
60	Laboratory	1,073,011	66,285,345	0.016188	17,109,706	276,972	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	67,276	11,475,457	0.005863	3,505,029	20,550	63
65	Respiratory Therapy	320,313	27,288,014	0.011738	6,471,325	75,960	65
66	Physical Therapy	86,330	6,699,922	0.012885	2,298,236	29,613	66
69	Electrocardiology	327,042	27,828,572	0.011752	4,649,234	54,638	69
70	Electroencephalography	130,096	9,120,892	0.014264	334,853	4,776	70
71	Medical Supplies Charged to Patients	529,798	140,945,400	0.003759	34,292,374	128,905	71
72	Impl. Dev. Charged to Patients	788,744	89,606,678	0.008802	21,714,361	191,130	72
73	Drugs Charged to Patients	807,708	111,390,829	0.007251	24,255,392	175,876	73
74	Renal Dialysis	50,678	1,576,498	0.032146	1,056,105	33,950	74
76	GI LAB	333,924	6,449,034	0.051779	783,433	40,565	76
76.01	MRI	444,482	23,934,684	0.018571	2,354,045	43,717	76.01
76.02	CT SCAN	187,432	46,340,535	0.004045	6,815,207	27,568	76.02
76.03	CARDIAC CATHETERIZATION	407,310	23,000,451	0.017709	4,565,336	80,848	76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	50,580	2,191,984	0.023075			76.08
76.10	GENETIC SERVICES	114,630	745,520	0.153758			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	117,855	7,950,438	0.014824	6,529	97	90.01
90.02	ANTENATAL TEST CENTER	76,176	6,988,372	0.010900			90.02
90.03	CHILD PSYCHIATRIC CLINIC	23,612	265,648	0.088885			90.03
91	Emergency	990,805	53,733,971	0.018439	6,802,612	125,433	91
92	Observation Beds (Non-Distinct Part)	295,166	18,006,614	0.016392			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	11,707,109	848,136,907		163,036,651	2,044,639	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		144,540			144,540	30
31	Intensive Care Unit		78,895			78,895	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
34.01	NEONATAL INTENSIVE CARE		31,033			31,033	34.01
34.02	PEDIATRIC INTENSIVE CARE		2,663			2,663	34.02
35	Other Special Care (specify)						35
40	Subprovider - IPF		10,694			10,694	40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery		7,099			7,099	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		274,924			274,924	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check [] Title V [XX] PPS
 Applicable [XX] Title XVIII, Part A [] TEFRA
 Boxes: [] Title XIX [] Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	47,775	3.03	18,562	56,243	30
31	Intensive Care Unit	5,185	15.22	2,133	32,464	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	11,956	2.60			34.01
34.02	PEDIATRIC INTENSIVE CARE	1,026	2.60			34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	4,120	2.60	995	2,587	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,735	2.60			43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,797		21,690	91,294	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART IV

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			171,291		171,291	171,291	50
51	Recovery Room							51
52	Delivery Room & Labor Room			32,719		32,719	32,719	52
53	Anesthesiology							53
54	Radiology-Diagnostic			309,821		309,821	309,821	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy			25,020		25,020	25,020	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	Emergency			904,571		904,571	904,571	91
92	Observation Beds (Non-Distinct Part)			14,202		14,202	14,202	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			1,457,624		1,457,624	1,457,624	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	66,344,211	0.002582	0.002582	14,142,960	36,517	11,250,544	29,049	50
51	Recovery Room	8,116,736			1,654,273		926,250		51
52	Delivery Room & Labor Room	16,529,064	0.001979	0.001979	11,728	23	7,086	14	52
53	Anesthesiology	12,138,588			2,016,720		1,583,190		53
54	Radiology-Diagnostic	43,520,614	0.007119	0.007119	7,218,865	51,391	6,401,844	45,575	54
55	Radiology-Therapeutic	11,022,415			95,986		2,908,801		55
56	Radioisotope	8,640,421			882,342		2,511,160		56
60	Laboratory	66,285,345			17,109,706		4,288,307		60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	11,475,457			3,505,029		541,624		63
65	Respiratory Therapy	27,288,014	0.000917	0.000917	6,471,325	5,934	404,529	371	65
66	Physical Therapy	6,699,922			2,298,236		229		66
69	Electrocardiology	27,828,572			4,649,234		4,799,742		69
70	Electroencephalography	9,120,892			334,853		1,728,409		70
71	Medical Supplies Charged to Patients	140,945,400			34,292,374		13,297,847		71
72	Impl. Dev. Charged to Patients	89,606,678			21,714,361		9,419,430		72
73	Drugs Charged to Patients	111,390,829			24,255,392		15,450,748		73
74	Renal Dialysis	1,576,498			1,056,105		32,080		74
76	GI LAB	6,449,034			783,433		1,046,773		76
76.01	MRI	23,934,684			2,354,045		3,893,677		76.01
76.02	CT SCAN	46,340,535			6,815,207		7,661,284		76.02
76.03	CARDIAC CATHETERIZATION	23,000,451			4,565,336		4,684,288		76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,191,984							76.08
76.10	GENETIC SERVICES	745,520							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	7,950,438			6,529		148,869		90.01
90.02	ANTENATAL TEST CENTER	6,988,372							90.02
90.03	CHILD PSYCHIATRIC CLINIC	265,648							90.03
91	Emergency	53,733,971	0.016834	0.016834	6,802,612	114,515	9,697,642	163,250	91
92	Observation Beds (Non-Distinct Part)	18,006,614	0.000789	0.000789			2,182,592	1,722	92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	848,136,907			163,036,651	208,380	104,866,945	239,981	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/MR

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.583767	11,250,544			6,567,696			50
51	Recovery Room	0.266194	926,250			246,562			51
52	Delivery Room & Labor Room	0.414236	7,086			2,935			52
53	Anesthesiology	0.248114	1,583,190			392,812			53
54	Radiology-Diagnostic	0.175487	6,401,844			1,123,440			54
55	Radiology-Therapeutic	0.276080	2,908,801			803,062			55
56	Radioisotope	0.143034	2,511,160			359,181			56
60	Laboratory	0.249235	4,288,307			1,068,796			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	0.159535	541,624			86,408			63
65	Respiratory Therapy	0.217580	404,529			88,017			65
66	Physical Therapy	0.398436	229			91			66
69	Electrocardiology	0.112921	4,799,742			541,992			69
70	Electroencephalography	0.181529	1,728,409			313,756			70
71	Medical Supplies Charged to Patients	0.114883	13,297,847			1,527,697			71
72	Impl. Dev. Charged to Patients	0.267724	9,419,430			2,521,807			72
73	Drugs Charged to Patients	0.219278	15,450,748		200,184	3,388,009		43,896	73
74	Renal Dialysis	0.679042	32,080			21,784			74
76	GI LAB	0.285879	1,046,773			299,250			76
76.01	MRI	0.081884	3,893,677			318,830			76.01
76.02	CT SCAN	0.042441	7,661,284			325,153			76.02
76.03	CARDIAC CATHETERIZATION	0.129476	4,684,288			606,503			76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856							76.08
76.10	GENETIC SERVICES	2.446207							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.184893	148,869			27,525			90.01
90.02	ANTENATAL TEST CENTER	0.169706							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465							90.03
91	Emergency	0.284913	9,697,642			2,762,984			91
92	Observation Beds (Non-Distinct Part)	0.290491	2,182,592			634,023			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	1.459626							95
200	Subtotal (see instructions)		104,866,945		200,184	24,028,313		43,896	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		104,866,945		200,184	24,028,313		43,896	202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART II

Check [] Title V [] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] TEFRA
 Boxes: [] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5			
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,509,492	66,344,211	0.037825			50
51	Recovery Room	67,705	8,116,736	0.008341			51
52	Delivery Room & Labor Room	446,460	16,529,064	0.027011			52
53	Anesthesiology	287,460	12,138,588	0.023682			53
54	Radiology-Diagnostic	786,669	43,520,614	0.018076	13,073	236	54
55	Radiology-Therapeutic	350,418	11,022,415	0.031791			55
56	Radioisotope	35,937	8,640,421	0.004159			56
60	Laboratory	1,073,011	66,285,345	0.016188	196,226	3,177	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	67,276	11,475,457	0.005863			63
65	Respiratory Therapy	320,313	27,288,014	0.011738	5,726	67	65
66	Physical Therapy	86,330	6,699,922	0.012885	6,966	90	66
69	Electrocardiology	327,042	27,828,572	0.011752	6,161	72	69
70	Electroencephalography	130,096	9,120,892	0.014264	2,942	42	70
71	Medical Supplies Charged to Patients	529,798	140,945,400	0.003759	1,167	4	71
72	Impl. Dev. Charged to Patients	788,744	89,606,678	0.008802			72
73	Drugs Charged to Patients	807,708	111,390,829	0.007251	165,509	1,200	73
74	Renal Dialysis	50,678	1,576,498	0.032146			74
76	GI LAB	333,924	6,449,034	0.051779			76
76.01	MRI	444,482	23,934,684	0.018571	25,005	464	76.01
76.02	CT SCAN	187,432	46,340,535	0.004045	12,846	52	76.02
76.03	CARDIAC CATHETERIZATION	407,310	23,000,451	0.017709	1,096	19	76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	50,580	2,191,984	0.023075			76.08
76.10	GENETIC SERVICES	114,630	745,520	0.153758			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	117,855	7,950,438	0.014824			90.01
90.02	ANTENATAL TEST CENTER	76,176	6,988,372	0.010900			90.02
90.03	CHILD PSYCHIATRIC CLINIC	23,612	265,648	0.088885			90.03
91	Emergency	990,805	53,733,971	0.018439	130,853	2,413	91
92	Observation Beds (Non-Distinct Part)		18,006,614				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	11,411,943	848,136,907		567,570	7,836	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			171,291		171,291	171,291	50
51	Recovery Room							51
52	Delivery Room & Labor Room			32,719		32,719	32,719	52
53	Anesthesiology							53
54	Radiology-Diagnostic			309,821		309,821	309,821	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy			25,020		25,020	25,020	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	Emergency			904,571		904,571	904,571	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			1,443,422		1,443,422	1,443,422	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/MR [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	66,344,211	0.002582	0.002582					50
51	Recovery Room	8,116,736							51
52	Delivery Room & Labor Room	16,529,064	0.001979	0.001979					52
53	Anesthesiology	12,138,588							53
54	Radiology-Diagnostic	43,520,614	0.007119	0.007119	13,073	93			54
55	Radiology-Therapeutic	11,022,415							55
56	Radioisotope	8,640,421							56
60	Laboratory	66,285,345			196,226				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	11,475,457							63
65	Respiratory Therapy	27,288,014	0.000917	0.000917	5,726	5			65
66	Physical Therapy	6,699,922			6,966				66
69	Electrocardiology	27,828,572			6,161				69
70	Electroencephalography	9,120,892			2,942				70
71	Medical Supplies Charged to Patients	140,945,400			1,167				71
72	Impl. Dev. Charged to Patients	89,606,678							72
73	Drugs Charged to Patients	111,390,829			165,509				73
74	Renal Dialysis	1,576,498							74
76	GI LAB	6,449,034							76
76.01	MRI	23,934,684			25,005				76.01
76.02	CT SCAN	46,340,535			12,846				76.02
76.03	CARDIAC CATHETERIZATION	23,000,451			1,096				76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,191,984							76.08
76.10	GENETIC SERVICES	745,520							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	7,950,438					272		90.01
90.02	ANTENATAL TEST CENTER	6,988,372							90.02
90.03	CHILD PSYCHIATRIC CLINIC	265,648							90.03
91	Emergency	53,733,971	0.016834	0.016834	130,853	2,203			91
92	Observation Beds (Non-Distinct Part)	18,006,614							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	848,136,907			567,570	2,301	272		200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [XX] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/MR

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.583767						50
51	Recovery Room	0.266194						51
52	Delivery Room & Labor Room	0.414236						52
53	Anesthesiology	0.248114						53
54	Radiology-Diagnostic	0.175487						54
55	Radiology-Therapeutic	0.276080						55
56	Radioisotope	0.143034						56
60	Laboratory	0.249235						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	0.159535						63
65	Respiratory Therapy	0.217580						65
66	Physical Therapy	0.398436						66
69	Electrocardiology	0.112921						69
70	Electroencephalography	0.181529						70
71	Medical Supplies Charged to Patients	0.114883						71
72	Impl. Dev. Charged to Patients	0.267724						72
73	Drugs Charged to Patients	0.219278						73
74	Renal Dialysis	0.679042						74
76	GI LAB	0.285879						76
76.01	MRI	0.081884						76.01
76.02	CT SCAN	0.042441						76.02
76.03	CARDIAC CATHETERIZATION	0.129476						76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856						76.08
76.10	GENETIC SERVICES	2.446207						76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	0.184893	272			50		90.01
90.02	ANTENATAL TEST CENTER	0.169706						90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465						90.03
91	Emergency	0.284913						91
92	Observation Beds (Non-Distinct Part)	0.290491						92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1.459626						95
200	Subtotal (see instructions)		272			50		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		272			50		202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Title V
 Applicable Title XVIII, Part A
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,004,182		3,004,182	47,775	62.88	8,919	560,827	30
31	Intensive Care Unit	557,010		557,010	5,185	107.43	1,101	118,280	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	599,472		599,472	11,956	50.14	7,489	375,498	34.01
34.02	PEDIATRIC INTENSIVE CARE	96,790		96,790	1,026	94.34	643	60,661	34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	188,209		188,209	4,120	45.68	1,112	50,796	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	116,415		116,415	2,735	42.56	1,713	72,905	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,562,078		4,562,078	72,797		20,977	1,238,967	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART II

Check [] Title V [XX] Hospital [] SUB (Other)
 Applicable [] Title XVIII, Part A [] IPF
 Boxes: [XX] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5			
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,509,492	66,344,211	0.037825			50
51	Recovery Room	67,705	8,116,736	0.008341			51
52	Delivery Room & Labor Room	446,460	16,529,064	0.027011			52
53	Anesthesiology	287,460	12,138,588	0.023682			53
54	Radiology-Diagnostic	786,669	43,520,614	0.018076			54
55	Radiology-Therapeutic	350,418	11,022,415	0.031791			55
56	Radioisotope	35,937	8,640,421	0.004159			56
60	Laboratory	1,073,011	66,285,345	0.016188			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	67,276	11,475,457	0.005863			63
65	Respiratory Therapy	320,313	27,288,014	0.011738			65
66	Physical Therapy	86,330	6,699,922	0.012885			66
69	Electrocardiology	327,042	27,828,572	0.011752			69
70	Electroencephalography	130,096	9,120,892	0.014264			70
71	Medical Supplies Charged to Patients	529,798	140,945,400	0.003759			71
72	Impl. Dev. Charged to Patients	788,744	89,606,678	0.008802			72
73	Drugs Charged to Patients	807,708	111,390,829	0.007251			73
74	Renal Dialysis	50,678	1,576,498	0.032146			74
76	GI LAB	333,924	6,449,034	0.051779			76
76.01	MRI	444,482	23,934,684	0.018571			76.01
76.02	CT SCAN	187,432	46,340,535	0.004045			76.02
76.03	CARDIAC CATHETERIZATION	407,310	23,000,451	0.017709			76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	50,580	2,191,984	0.023075			76.08
76.10	GENETIC SERVICES	114,630	745,520	0.153758			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	117,855	7,950,438	0.014824			90.01
90.02	ANTENATAL TEST CENTER	76,176	6,988,372	0.010900			90.02
90.03	CHILD PSYCHIATRIC CLINIC	23,612	265,648	0.088885			90.03
91	Emergency	990,805	53,733,971	0.018439			91
92	Observation Beds (Non-Distinct Part)	295,166	18,006,614	0.016392			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	11,707,109	848,136,907				200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)		144,540			144,540	30
31	Intensive Care Unit		78,895			78,895	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
34.01	NEONATAL INTENSIVE CARE		31,033			31,033	34.01
34.02	PEDIATRIC INTENSIVE CARE		2,663			2,663	34.02
35	Other Special Care (specify)						35
40	Subprovider - IPF		10,694			10,694	40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery		7,099			7,099	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		274,924			274,924	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	47,775	3.03	8,919	27,025	30
31	Intensive Care Unit	5,185	15.22	1,101	16,757	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	11,956	2.60	7,489	19,471	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,026	2.60	643	1,672	34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	4,120	2.60	1,112	2,891	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,735	2.60	1,713	4,454	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	72,797		20,977	72,270	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			171,291		171,291	171,291	50
51	Recovery Room							51
52	Delivery Room & Labor Room			32,719		32,719	32,719	52
53	Anesthesiology							53
54	Radiology-Diagnostic			309,821		309,821	309,821	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy			25,020		25,020	25,020	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	Emergency			904,571		904,571	904,571	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			1,443,422		1,443,422	1,443,422	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/MR [] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [XX] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	66,344,211	0.002582	0.002582					50
51	Recovery Room	8,116,736							51
52	Delivery Room & Labor Room	16,529,064	0.001979	0.001979					52
53	Anesthesiology	12,138,588							53
54	Radiology-Diagnostic	43,520,614	0.007119	0.007119					54
55	Radiology-Therapeutic	11,022,415							55
56	Radioisotope	8,640,421							56
60	Laboratory	66,285,345							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	11,475,457							63
65	Respiratory Therapy	27,288,014	0.000917	0.000917					65
66	Physical Therapy	6,699,922							66
69	Electrocardiology	27,828,572							69
70	Electroencephalography	9,120,892							70
71	Medical Supplies Charged to Patients	140,945,400							71
72	Impl. Dev. Charged to Patients	89,606,678							72
73	Drugs Charged to Patients	111,390,829							73
74	Renal Dialysis	1,576,498							74
76	GI LAB	6,449,034							76
76.01	MRI	23,934,684							76.01
76.02	CT SCAN	46,340,535							76.02
76.03	CARDIAC CATHETERIZATION	23,000,451							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,191,984							76.08
76.10	GENETIC SERVICES	745,520							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	7,950,438							90.01
90.02	ANTENATAL TEST CENTER	6,988,372							90.02
90.03	CHILD PSYCHIATRIC CLINIC	265,648							90.03
91	Emergency	53,733,971	0.016834	0.016834					91
92	Observation Beds (Non-Distinct Part)	18,006,614							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	848,136,907							200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0239

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/MR

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.583767							50
51	Recovery Room	0.266194							51
52	Delivery Room & Labor Room	0.414236							52
53	Anesthesiology	0.248114							53
54	Radiology-Diagnostic	0.175487							54
55	Radiology-Therapeutic	0.276080							55
56	Radioisotope	0.143034							56
60	Laboratory	0.249235							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	0.159535							63
65	Respiratory Therapy	0.217580							65
66	Physical Therapy	0.398436							66
69	Electrocardiology	0.112921							69
70	Electroencephalography	0.181529							70
71	Medical Supplies Charged to Patients	0.114883							71
72	Impl. Dev. Charged to Patients	0.267724							72
73	Drugs Charged to Patients	0.219278							73
74	Renal Dialysis	0.679042							74
76	GI LAB	0.285879							76
76.01	MRI	0.081884							76.01
76.02	CT SCAN	0.042441							76.02
76.03	CARDIAC CATHETERIZATION	0.129476							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856							76.08
76.10	GENETIC SERVICES	2.446207							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.184893							90.01
90.02	ANTENATAL TEST CENTER	0.169706							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465							90.03
91	Emergency	0.284913							91
92	Observation Beds (Non-Distinct Part)	0.290491							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	1.459626							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART II

Check [] Title V [] Hospital [] SUB (Other)
 Applicable [] Title XVIII, Part A [XX] IPF
 Boxes: [XX] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,509,492	66,344,211	0.037825			50
51	Recovery Room	67,705	8,116,736	0.008341			51
52	Delivery Room & Labor Room	446,460	16,529,064	0.027011			52
53	Anesthesiology	287,460	12,138,588	0.023682			53
54	Radiology-Diagnostic	786,669	43,520,614	0.018076			54
55	Radiology-Therapeutic	350,418	11,022,415	0.031791			55
56	Radioisotope	35,937	8,640,421	0.004159			56
60	Laboratory	1,073,011	66,285,345	0.016188			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	67,276	11,475,457	0.005863			63
65	Respiratory Therapy	320,313	27,288,014	0.011738			65
66	Physical Therapy	86,330	6,699,922	0.012885			66
69	Electrocardiology	327,042	27,828,572	0.011752			69
70	Electroencephalography	130,096	9,120,892	0.014264			70
71	Medical Supplies Charged to Patients	529,798	140,945,400	0.003759			71
72	Impl. Dev. Charged to Patients	788,744	89,606,678	0.008802			72
73	Drugs Charged to Patients	807,708	111,390,829	0.007251			73
74	Renal Dialysis	50,678	1,576,498	0.032146			74
76	GI LAB	333,924	6,449,034	0.051779			76
76.01	MRI	444,482	23,934,684	0.018571			76.01
76.02	CT SCAN	187,432	46,340,535	0.004045			76.02
76.03	CARDIAC CATHETERIZATION	407,310	23,000,451	0.017709			76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	50,580	2,191,984	0.023075			76.08
76.10	GENETIC SERVICES	114,630	745,520	0.153758			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	117,855	7,950,438	0.014824			90.01
90.02	ANTENATAL TEST CENTER	76,176	6,988,372	0.010900			90.02
90.03	CHILD PSYCHIATRIC CLINIC	23,612	265,648	0.088885			90.03
91	Emergency	990,805	53,733,971	0.018439			91
92	Observation Beds (Non-Distinct Part)		18,006,614				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	11,411,943	848,136,907				200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/MR [] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [XX] Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			171,291		171,291	171,291	50
51	Recovery Room							51
52	Delivery Room & Labor Room			32,719		32,719	32,719	52
53	Anesthesiology							53
54	Radiology-Diagnostic			309,821		309,821	309,821	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy			25,020		25,020	25,020	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	Emergency			904,571		904,571	904,571	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			1,443,422		1,443,422	1,443,422	200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S239

**WORKSHEET D
PART IV**

Check [] Title V [] Hospital [] SUB (Other) [] ICF/MR [] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [XX] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	66,344,211	0.002582	0.002582					50
51	Recovery Room	8,116,736							51
52	Delivery Room & Labor Room	16,529,064	0.001979	0.001979					52
53	Anesthesiology	12,138,588							53
54	Radiology-Diagnostic	43,520,614	0.007119	0.007119					54
55	Radiology-Therapeutic	11,022,415							55
56	Radioisotope	8,640,421							56
60	Laboratory	66,285,345							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Trans.	11,475,457							63
65	Respiratory Therapy	27,288,014	0.000917	0.000917					65
66	Physical Therapy	6,699,922							66
69	Electrocardiology	27,828,572							69
70	Electroencephalography	9,120,892							70
71	Medical Supplies Charged to Patients	140,945,400							71
72	Impl. Dev. Charged to Patients	89,606,678							72
73	Drugs Charged to Patients	111,390,829							73
74	Renal Dialysis	1,576,498							74
76	GI LAB	6,449,034							76
76.01	MRI	23,934,684							76.01
76.02	CT SCAN	46,340,535							76.02
76.03	CARDIAC CATHETERIZATION	23,000,451							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,191,984							76.08
76.10	GENETIC SERVICES	745,520							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	7,950,438							90.01
90.02	ANTENATAL TEST CENTER	6,988,372							90.02
90.03	CHILD PSYCHIATRIC CLINIC	265,648							90.03
91	Emergency	53,733,971	0.016834	0.016834					91
92	Observation Beds (Non-Distinct Part)	18,006,614							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	848,136,907							200

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S239

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [] Title XVIII, Part B [XX] IPF [] SNF [] Swing Bed NF
 Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/MR

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.583767						50
51	Recovery Room	0.266194						51
52	Delivery Room & Labor Room	0.414236						52
53	Anesthesiology	0.248114						53
54	Radiology-Diagnostic	0.175487						54
55	Radiology-Therapeutic	0.276080						55
56	Radioisotope	0.143034						56
60	Laboratory	0.249235						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	0.159535						63
65	Respiratory Therapy	0.217580						65
66	Physical Therapy	0.398436						66
69	Electrocardiology	0.112921						69
70	Electroencephalography	0.181529						70
71	Medical Supplies Charged to Patients	0.114883						71
72	Impl. Dev. Charged to Patients	0.267724						72
73	Drugs Charged to Patients	0.219278						73
74	Renal Dialysis	0.679042						74
76	GI LAB	0.285879						76
76.01	MRI	0.081884						76.01
76.02	CT SCAN	0.042441						76.02
76.03	CARDIAC CATHETERIZATION	0.129476						76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856						76.08
76.10	GENETIC SERVICES	2.446207						76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	0.184893						90.01
90.02	ANTENATAL TEST CENTER	0.169706						90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465						90.03
91	Emergency	0.284913						91
92	Observation Beds (Non-Distinct Part)	0.290491						92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1.459626						95
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

**WORKSHEET D-1
PART I**

Check Title V - I/P Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	47,775	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	47,775	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	43,081	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	18,562	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	613.53	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	215.15	20
21	Total general inpatient routine service cost (see instructions)	53,237,922	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	53,237,922	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 35 x line 31)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	53,237,922	37

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART II

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1					
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,114.35	38				
39	Program general inpatient routine service cost (line 9 x line 38)						20,684,565	39				
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40				
41	Total Program general inpatient routine service cost (line 39 + line 40)						20,684,565	41				
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)						
		1	2	3	4	5						
42	Nursery (Titles V and XIX only)							42				
	Intensive Care Type Inpatient Hospital Units											
43	Intensive Care Unit						11,965,436	5,185	2,307.70	2,133	4,922,324	43
44	Coronary Care Unit											44
45	Burn Intensive Care Unit											45
46	Surgical Intensive Care Unit											46
46.01	NEONATAL INTENSIVE CARE						12,974,420	11,956	1,085.18			46.01
46.02	PEDIATRIC INTENSIVE CARE						2,734,384	1,026	2,665.09			46.02
47	Other Special Care (specify)											47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						37,722,929	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						63,329,818	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,485,034	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						2,253,019	51
52	Total Program excludable cost (sum of lines 50 and 51)						3,738,053	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthesiologist and medical education costs (line 49 minus line 52)						59,591,765	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4,694	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,114.35	88
89	Observation bed cost (line 87 x line 88) (see instructions)					5,230,759	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	3,004,182	53,237,922	0.056429	5,230,759	295,166	90
91	Nursing School						91
92	Allied Health	144,540	53,237,922	0.002715	5,230,759	14,202	92
93	Other Medical Education						93

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,120	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,120	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,120	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	995	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,937,330	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,937,330	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,937,330	37

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART II

Check [] Title V - I/P [] Hospital [] SUB (Other) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] TEFRA
 Boxes: [] Title XIX - I/P [] IRF [] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	955.66	38
39	Program general inpatient routine service cost (line 9 x line 38)	950,882	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	950,882	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	133,078	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,083,960	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	48,039	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,137	51
52	Total Program excludable cost (sum of lines 50 and 51)	58,176	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthesiologist and medical education costs (line 49 minus line 52)	1,025,784	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	47,775	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	47,775	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	43,081	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,919	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	2,735	15
16	Nursery days (title V or XIX only)	1,713	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	613.53	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	215.15	20
21	Total general inpatient routine service cost (see instructions)	53,185,498	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	53,185,498	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	53,185,498	37

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART II

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] PPS
 Applicable [] Title XVIII, Part A [] IPF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,113.25	38	
39	Program general inpatient routine service cost (line 9 x line 38)					9,929,077	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					9,929,077	41	
42	Nursery (Titles V and XIX only)	4,252,734	2,735	1,554.93	1,713	2,663,595	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	11,965,436	5,185	2,307.70	1,101	2,540,778	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
46.01	NEONATAL INTENSIVE CARE	12,931,329	11,956	1,081.58	7,489	8,099,953	46.01	
46.02	PEDIATRIC INTENSIVE CARE	2,734,384	1,026	2,665.09	643	1,713,653	46.02	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					24,947,056	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,257,550	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					1,257,550	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetic and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/MR PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					4,694	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART I

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/MR [] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [] NF [XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,120	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,120	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	4,120	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,112	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,937,330	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,937,330	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,937,330	37

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	955.66	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,062,694	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,062,694	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,062,694	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	53,687	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	53,687	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0239

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/MR [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics		18,014,367		30
31	Intensive Care Unit		6,185,405		31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	Subprovider - IPF				40
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.588138	14,142,960	8,318,012	50
51	Recovery Room	0.266194	1,654,273	440,358	51
52	Delivery Room & Labor Room	0.466078	11,728	5,466	52
53	Anesthesiology	0.380712	2,016,720	767,790	53
54	Radiology-Diagnostic	0.175487	7,218,865	1,266,817	54
55	Radiology-Therapeutic	0.276080	95,986	26,500	55
56	Radioisotope	0.143034	882,342	126,205	56
60	Laboratory	0.249235	17,109,706	4,264,338	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.159535	3,505,029	559,175	63
65	Respiratory Therapy	0.218211	6,471,325	1,412,114	65
66	Physical Therapy	0.398436	2,298,236	915,700	66
69	Electrocardiology	0.112921	4,649,234	524,996	69
70	Electroencephalography	0.181529	334,853	60,786	70
71	Medical Supplies Charged to Patients	0.114883	34,292,374	3,939,611	71
72	Impl. Dev. Charged to Patients	0.267724	21,714,361	5,813,456	72
73	Drugs Charged to Patients	0.219278	24,255,392	5,318,674	73
74	Renal Dialysis	0.679042	1,056,105	717,140	74
76	GI LAB	0.285879	783,433	223,967	76
76.01	MRI	0.081884	2,354,045	192,759	76.01
76.02	CT SCAN	0.042441	6,815,207	289,244	76.02
76.03	CARDIAC CATHETERIZATION	0.129476	4,565,336	591,101	76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856			76.08
76.10	GENETIC SERVICES	2.446207			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	PAIN CENTER	0.184893	6,529	1,207	90.01
90.02	ANTENATAL TEST CENTER	0.169706			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465			90.03
91	Emergency	0.286289	6,802,612	1,947,513	91
92	Observation Beds (Non-Distinct Part)	0.290491			92
OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		163,036,651	37,722,929	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		163,036,651		202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S239

WORKSHEET D-3

Check [] Title V [] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/MR [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	Subprovider - IPF		1,205,615		40
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.588138			50
51	Recovery Room	0.266194			51
52	Delivery Room & Labor Room	0.466078			52
53	Anesthesiology	0.380712			53
54	Radiology-Diagnostic	0.175487	13,073	2,294	54
55	Radiology-Therapeutic	0.276080			55
56	Radioisotope	0.143034			56
60	Laboratory	0.249235	196,226	48,906	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.159535			63
65	Respiratory Therapy	0.218211	5,726	1,249	65
66	Physical Therapy	0.398436	6,966	2,776	66
69	Electrocardiology	0.112921	6,161	696	69
70	Electroencephalography	0.181529	2,942	534	70
71	Medical Supplies Charged to Patients	0.114883	1,167	134	71
72	Impl. Dev. Charged to Patients	0.267724			72
73	Drugs Charged to Patients	0.219278	165,509	36,292	73
74	Renal Dialysis	0.679042			74
76	GI LAB	0.285879			76
76.01	MRI	0.081884	25,005	2,048	76.01
76.02	CT SCAN	0.042441	12,846	545	76.02
76.03	CARDIAC CATHETERIZATION	0.129476	1,096	142	76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856			76.08
76.10	GENETIC SERVICES	2.446207			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	PAIN CENTER	0.184893			90.01
90.02	ANTENATAL TEST CENTER	0.169706			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465			90.03
91	Emergency	0.286289	130,853	37,462	91
92	Observation Beds (Non-Distinct Part)	0.290491			92
OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		567,570	133,078	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		567,570		202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0239

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/MR Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.583767			50
51	Recovery Room	0.266194			51
52	Delivery Room & Labor Room	0.414236			52
53	Anesthesiology	0.248114			53
54	Radiology-Diagnostic	0.175487			54
55	Radiology-Therapeutic	0.276080			55
56	Radioisotope	0.143034			56
60	Laboratory	0.249235			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.159535			63
65	Respiratory Therapy	0.217580			65
66	Physical Therapy	0.398436			66
69	Electrocardiology	0.112921			69
70	Electroencephalography	0.181529			70
71	Medical Supplies Charged to Patients	0.114883			71
72	Impl. Dev. Charged to Patients	0.267724			72
73	Drugs Charged to Patients	0.219278			73
74	Renal Dialysis	0.679042			74
76	GI LAB	0.285879			76
76.01	MRI	0.081884			76.01
76.02	CT SCAN	0.042441			76.02
76.03	CARDIAC CATHETERIZATION	0.129476			76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856			76.08
76.10	GENETIC SERVICES	2.446207			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.184893			90.01
90.02	ANTENATAL TEST CENTER	0.169706			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465			90.03
91	Emergency	0.284913			91
92	Observation Beds (Non-Distinct Part)	0.290491			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S239

WORKSHEET D-3

Check [] Title V [] Hospital [] SUB (Other) [] Swing Bed SNF [] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] ICF/MR [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.583767			50
51	Recovery Room	0.266194			51
52	Delivery Room & Labor Room	0.414236			52
53	Anesthesiology	0.248114			53
54	Radiology-Diagnostic	0.175487			54
55	Radiology-Therapeutic	0.276080			55
56	Radioisotope	0.143034			56
60	Laboratory	0.249235			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.159535			63
65	Respiratory Therapy	0.217580			65
66	Physical Therapy	0.398436			66
69	Electrocardiology	0.112921			69
70	Electroencephalography	0.181529			70
71	Medical Supplies Charged to Patients	0.114883			71
72	Impl. Dev. Charged to Patients	0.267724			72
73	Drugs Charged to Patients	0.219278			73
74	Renal Dialysis	0.679042			74
76	GI LAB	0.285879			76
76.01	MRI	0.081884			76.01
76.02	CT SCAN	0.042441			76.02
76.03	CARDIAC CATHETERIZATION	0.129476			76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.359856			76.08
76.10	GENETIC SERVICES	2.446207			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.184893			90.01
90.02	ANTENATAL TEST CENTER	0.169706			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.638465			90.03
91	Emergency	0.284913			91
92	Observation Beds (Non-Distinct Part)	0.290491			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	27,457,422			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,079,711			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	3,411,313			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				
3	Managed care simulated payments	11,763,662			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	288.11			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0485			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3576			31
32	Sum of lines 30 and 31	0.4061			32
33	Allowable disproportionate share percentage (see instructions)	0.2271			33
34	Disproportionate share adjustment (see instructions)	2,131,171			34
		Prior to	On or after		
		October 1	October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	5,936,185	4,617,142		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,439,940	1,163,774		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,603,714			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	48,683,331			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	48,683,331			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,383,728			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment	153,330			53
54	Special add-on payments for new technologies	9,877			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).	88,707			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	208,380			58
59	Total (sum of amounts on lines 49 through 58)	52,527,353			59
60	Primary payer payments	58,187			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	52,469,166			61
62	Deductibles billed to program beneficiaries	3,736,699			62
63	Coinsurance billed to program beneficiaries	114,824			63
64	Allowable bad debts (see instructions)	904,469			64
65	Adjusted reimbursable bad debts (see instructions)	587,905			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	901,849			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	49,205,548			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (MEDI/MEDI BAD DEBT RETROACTIVE ADJ)				70
70.93	HVBP payment adjustment amount (see instructions)	-73,328			70.93
71	Amount due provider (see instructions)	49,132,220			71
71.01	Sequestration adjustment (see instructions)	982,644			71.01
72	Interim payments	47,114,229			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,035,347			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	1,230,669			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1						1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1						1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges						2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments						4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21						5
6	IME payment adjustment						6
6.01	IME payment adjustment for managed care						6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)						9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)						9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage						10
11	Disproportionate share adjustment						11
11.01	Uncompensated care payments						11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal						13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)						14
15	Total payment for inpatient operating costs SCH and MDH only						15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)						16
17	Special add-on payments for new technologies						17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL						19
20	Capital DRG other than outlier						20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments						21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage						22
23	Indirect medical education adjustment						23
24	Allowable disproportionate share percentage						24
25	Disproportionate share adjustment						25
26	Total prospective capital payments						26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1						29
30	HVBP payment adjustment						30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment						31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment						32

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0239

**WORKSHEET E
PART B**

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	43,896			1
2	Medical and other services reimbursed under OPSS (see instructions)	23,788,332			2
3	PPS payments	18,435,313			3
4	Outlier payment (see instructions)	142,067			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	239,981			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	43,896			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	200,184			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	200,184			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	200,184			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	156,288			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	43,896			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	18,817,361			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,871,948			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	14,989,309			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	14,989,309			30
31	Primary payer payments	4,744			31
32	Subtotal (line 30 minus line 31)	14,984,565			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	865,005			34
35	Adjusted reimbursable bad debts (see instructions)	562,253			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	863,285			36
37	Subtotal (see instructions)	15,546,818			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (FORMULA DRIVEN OVERPAYMENT EST)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	15,546,818			40
40.01	Sequestration adjustment (see instructions)	310,936			40.01
41	Interim payments	15,015,510			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	220,372			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S239

**WORKSHEET E
PART B**

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	50			2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0239

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		47,114,229		15,015,510	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
						3.01
						3.02
	Program					3.03
	to					3.04
	Provider					3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
	Provider					3.52
	to					3.53
	Program					3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		47,114,229		15,015,510	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
						5.01
						5.02
	Program					5.03
	to					5.04
	Provider					5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
	Provider					5.52
	to					5.53
	Program					5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		2,017,991		531,308	6.01
7	Total Medicare program liability (see instructions)		49,132,220		15,546,818	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S239

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		665,478		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		665,478		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	24,936		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		690,414		7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	12,681	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	20,695	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	6,028	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	61,248	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	963,938,062	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	35,485,039	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	1,463,099	8
9	Sequestration adjustment amount (see instructions)	29,262	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,433,837	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	1,451,570	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-17,733	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S239

WORKSHEET E-3
PART II

Check [] Hospital
Applicable [XX] Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	795,676	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	11.287671	9
10	Teaching adjustment factor (((1 + (line 8/line 9)) raised to the power of .5150 - 1)		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	795,676	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	795,676	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	795,676	18
19	Deductibles	112,960	19
20	Subtotal (line 18 minus line 19)	682,716	20
21	Coinsurance	3,648	21
22	Subtotal (line 20 minus line 21)	679,068	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,935	23
24	Adjusted reimbursable bad debts (see instructions)	6,458	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,935	25
26	Subtotal (sum of lines 22 and 24)	685,526	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)	4,888	28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	690,414	31
31.01	Sequestration adjustment (see instructions)	13,808	31.01
32	Interim payments	665,478	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	11,128	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0239

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/MR TEFRA
 Boxes: SNF SNF Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services	24,947,056		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	24,947,056		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	24,947,056		7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	24,947,056		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)	24,947,056		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S239

WORKSHEET E-3
PART VII

Check [] Title V [] Hospital [] NF [] PPS
 Applicable [XX] Title XIX [XX] Subprovider IPF [] ICF/MR [] TEFRA
 Boxes: [] SNF [XX] Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,062,694	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	1,062,694	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,062,694	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	Routine service charges		8
9	Ancillary service charges		9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)		12
CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis		13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,062,694	18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)		21
PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,062,694	30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)		38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)		40
41	Interim payments		41
42	Balance due provider/program (line 40 minus line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT ASSETS					
1	Cash on hand and in banks	39,289,175			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	54,330,535			4
5	Other receivables	4,286,739			5
6	Allowances for uncollectible notes and accounts receivable				6
7	Inventory	7,844,471			7
8	Prepaid expenses	1,612,135			8
9	Other current assets	13,160,000			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	120,523,055			11
FIXED ASSETS					
12	Land	2,600,972			12
13	Land improvements	7,340,745			13
14	Accumulated depreciation	-6,168,864			14
15	Buildings	54,804,308			15
16	Accumulated depreciation	-40,528,762			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	119,370,349			19
20	Accumulated depreciation	-82,021,244			20
21	Audomobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	124,882,444			23
24	Accumulated depreciation	-76,376,112			24
25	Minor equipment depreciable				25
26	Accumulated depreciation				26
27	HIT designated assets				27
28	Accumulated depreciation				28
29	Minor equipment-nondepreciable				29
30	Total fixed assets (sum of lines 12-29)	103,903,836			30
OTHER ASSETS					
31	Investments	102,751,877			31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	24,153,500			34
35	Total other assets (sum of lines 31-34)	126,905,377			35
36	Total assets (sum of lines 11, 30 and 35)	351,332,268			36
Liabilities and Fund Balances (Omit Cents)					
		1	2	3	4
CURRENT LIABILITIES					
37	Accounts payable	5,531,261			37
38	Salaries, wages and fees payable	26,569,099			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)	3,625,802			40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds	19,274			43
44	Other current liabilities	14,529,921			44
45	Total current liabilities (sum of lines 37 thru 44)	50,275,357			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable	58,741,862			47
48	Unsecured loans				48
49	Other long term liabilities	60,515,464			49
50	Total long term liabilities (sum of lines 46 thru 49)	119,257,326			50
51	Total liabilities (sum of lines 45 and 50)	169,532,683			51
CAPITAL ACCOUNTS					
52	General fund balance	181,799,585			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	181,799,585			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	351,332,268			60

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		182,455,165			1
2	Net income (loss) (from Worksheet G-3, line 29)		42,084,013			2
3	Total (sum of line 1 and line 2)		224,539,178			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		224,539,178			11
12	Deductions (debit adjustments) (specify)					12
13	OTHER	42,739,593				13
14						14
15						15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)		42,739,593			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		181,799,585			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	OTHER					13
14						14
15						15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES					
1	Hospital	42,328,759		42,328,759	1
2	Subprovider IPF	4,984,496		4,984,496	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	47,313,255		47,313,255	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES					
11	Intensive Care Unit	14,540,456		14,540,456	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
14.01	NEONATAL INTENSIVE CARE	49,050,928		49,050,928	14.01
14.02	PEDIATRIC INTENSIVE CARE	3,667,087		3,667,087	14.02
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	67,258,471		67,258,471	16
17	Total inpatient routine care services (sum of lines 10 and 16)	114,571,726		114,571,726	17
18	Ancillary services	458,979,225		458,979,225	18
19	Outpatient services		390,224,721	390,224,721	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FOHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	573,550,951	390,224,721	963,775,672	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		332,749,736	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	PHYSICIAN PRACTICE REVENUE	-377,529		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-377,529	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		332,372,207	43

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	963,775,672	1
2	Less contractual allowances and discounts on patients' accounts	655,951,880	2
3	Net patient revenues (line 1 minus line 2)	307,823,792	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	332,372,207	4
5	Net income from service to patients (line 3 minus line 4)	-24,548,415	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER OPERATING INCOME)	32,452,478	24
24.01	Other (OTHER NON-OPERATING INCOME)	6,321,680	24.01
24.02	Other (PROVIDER TAX)	27,858,270	24.02
25	Total other income (sum of lines 6-24)	66,632,428	25
26	Total (line 5 plus line 25)	42,084,013	26
29	Net income (or loss) for the period (line 26 minus line 28)	42,084,013	29

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0239

WORKSHEET L

Check Title V Hospital PPS
 Applicable Title XVIII, Part A SUB (Other) Cost Method
 Boxes: Title XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	2,995,231	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	131,806	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	173.06	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0485	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3576	8
9	Sum of lines 7 and 8	0.4061	9
10	Allowable disproportionate share percentage (see instructions)	0.0857	10
11	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	256,691	11
12	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	3,383,728	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	PARAMDICAL ED PROGRAM XRAY						23
23.01	PASTORAL EDUCATION PROGRAM						23.01
23.02	PARAMED EDUC EMT PROGRAM						23.02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
34.01	NEONATAL INTENSIVE CARE						34.01
34.02	PEDIATRIC INTENSIVE CARE						34.02
40	Subprovider - IPF						40
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.						63
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
76	GI LAB						76
76.01	MRI						76.01
76.02	CT SCAN						76.02
76.03	CARDIAC CATHETERIZATION						76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES						76.08
76.10	GENETIC SERVICES						76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER						90.01
90.02	ANTENATAL TEST CENTER						90.02
90.03	CHILD PSYCHIATRIC CLINIC						90.03
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/21/2015 Run Time: 19:04 Version: 2015.03 (05/17/2015)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER							194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES							194.0 2
194.0 4	AUXILIARY							194.0 4
194.0 7	ROCKFORD HEALTH SYSTEM							194.0 7
194.0 8	DIALYSIS RENTED SPACE							194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202