

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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: 11/18/2015 Time: 00:47		
	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

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

Title

Date

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
		PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	634,395	172,426			1
2	SUBPROVIDER - IPF	2,395				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	636,790	172,426			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						2

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 / 2015	To: 06 / 30 / 2015							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.	4,396		197		1,947	5,324	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 is in effect in the cost reporting period.							37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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?	N	Y	N
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	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

		1	2	3	
Teaching Hospitals					
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, chapter 21, 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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**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))
65	1	2	3	4	5
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))
67	1	2	3	4	5

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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (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
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.		N		87

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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/IID 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 is not made on Wkst. B, Pt. I, col. 25 and the program is 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, chapter 22, 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:	Premiums	Paid Losses	Self Insurance	
		2,566,127			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

		1	2	
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)	Y	149018	140

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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	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, chapter 40, §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.	N				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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	
7	Are costs claimed for allied health programs? If yes, see instructions.	Y	
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N	
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N	
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	

		Y/N
Bad Debts		Y/N
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		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	10/14/2015	Y	10/14/2015
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	42,897			8,901	5,065	20,522	1
2	HMO and other (see instructions)						2,807	1,947		2
3	HMO IPF Subprovider						109	558		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	42,897			8,901	5,065	20,522	7
8	Intensive Care Unit	31	21	3,982			1,008	1,078	2,267	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	8,326				2,302	5,935	11.01
11.02	PEDIATRIC INTENSIVE CARE	34.02	7	1,267				393	647	11.02
12	Other Special Care (specify)	35								12
13	Nursery	43						961	1,280	13
14	Total (see instructions)		311	56,472			9,909	9,799	30,651	14
15	CAH Visits									15
16	Subprovider - IPF	40	14	2,336			503	406	1,865	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									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							118	881	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)					2,153	3,208	6,405	1
2	HMO and other (see instructions)					625	630		2
3	HMO IPF Subprovider						93		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)		1,589.08			2,153	3,208	6,405	14
15	CAH Visits								15
16	Subprovider - IPF		25.73			82	55	282	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)		1,614.81						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication 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	53,031,859	-6,711,157	46,320,702	1,670,162.00	27.73	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		1,377,471	-98,570	1,278,901	66,159.00	19.33	10
OTHER WAGES & RELATED COSTS							
11		752,402		752,402	15,968.00	47.12	11
12							12
13		2,644,383		2,644,383	38,717.00	68.30	13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		17,874,823		17,874,823			17
18							18
19		667,123		667,123			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		1,247,528	-504,014	743,514	40,981.00	18.14	26
27		8,776,498	-5,771,665	3,004,833	110,864.00	27.10	27
28		1,075,282		1,075,282	6,414.00	167.65	28
29							29
30		1,278,984	-73,523	1,205,461	52,159.00	23.11	30
31		49,780		49,780	3,909.00	12.73	31
32		937,235		937,235	71,421.00	13.12	32
33		43,583		43,583	3,190.00	13.66	33
34		1,113,095	-750,539	362,556	24,001.00	15.11	34
35		207,012		207,012	3,840.00	53.91	35
36			750,539	750,539	55,507.00	13.52	36
37							37
38		1,580,721		1,580,721	31,458.00	50.25	38
39		651,065		651,065	39,518.00	16.48	39
40		1,883,692		1,883,692	46,307.00	40.68	40
41		685,632	-240,961	444,671	16,309.00	27.27	41
42		139,132	-22,424	116,708	3,664.00	31.85	42
43							43

Part III - Hospital Wage Index Summary

1		54,357,736	-6,711,157	47,646,579	1,683,606.00	28.30	1
2		1,377,471	-98,570	1,278,901	66,159.00	19.33	2
3		52,980,265	-6,612,587	46,367,678	1,617,447.00	28.67	3
4		3,396,785		3,396,785	54,685.00	62.12	4
5		17,874,823		17,874,823		38.55%	5
6		74,251,873	-6,612,587	67,639,286	1,672,132.00	40.45	6
7		19,669,239	-6,612,587	13,056,652	509,542.00	25.62	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	3,296,482	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		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)	10,146,645	8
9	Prescription Drug Plan	129	9
10	Dental, Hearing and Vision Plan	346,321	10
11	Life Insurance (If employee is owner or beneficiary)	12,903	11
12	Accident Insurance (If employee is owner or beneficiary)	-6	12
13	Disability Insurance (If employee is owner or beneficiary)	648,157	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)	4,150	14
15	Workers' Compensation Insurance	-49,550	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	248,152	16
	TAXES		
17	FICA-Employers Portion Only	3,403,869	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	34,214	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	450,454	23
24	Total Wage Related cost (Sum of lines 1-23)	18,541,920	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)		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	819,069	18,541,946	1
2	Hospital	752,402	17,877,269	2
3	Subprovider - IPF	66,667	378,651	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		286,026	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)		4	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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)		0.268123	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		29,717,640	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		22,934,829	5
6	Medicaid charges		145,794,295	6
7	Medicaid cost (line 1 times line 6)		39,090,804	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	1,004,419	264,393	1,268,812	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	269,308	70,890	340,198	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	269,308	70,890	340,198	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)		5,589,662	26
27	Medicare bad debts for the entire hospital complex (see instructions)		677,325	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,912,337	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,317,111	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		1,657,309	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,657,309	31

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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				114,360	114,360	-951	113,409	1
2	00200	Cap Rel Costs-Mvble Equip				8,905,306	8,905,306	-64,190	8,841,116	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	1,247,528	834,751	2,082,279	-1,003,515	1,078,764	-676,573	402,191	4
5	00500	Administrative & General	8,776,498	42,763,693	51,540,191	-1,165,427	50,374,764	-21,234,442	29,140,322	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,278,984	5,491,549	6,770,533	-763,072	6,007,461	-175,941	5,831,520	7
8	00800	Laundry & Linen Service	49,780	499,152	548,932	-3,688	545,244		545,244	8
9	00900	Housekeeping	937,235	819,762	1,756,997	-12,467	1,744,530	-47,826	1,696,704	9
10	01000	Dietary	1,113,095	1,560,478	2,673,573	-1,833,890	839,683		839,683	10
11	01100	Cafeteria				1,802,740	1,802,740	-887,013	915,727	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,580,721	711,027	2,291,748	-17,215	2,274,533	-79,888	2,194,645	13
14	01400	Central Services & Supply	651,065	1,146,616	1,797,681	-193,374	1,604,307		1,604,307	14
15	01500	Pharmacy	1,883,692	7,040,061	8,923,753	-6,150,118	2,773,635		2,773,635	15
16	01600	Medical Records & Library	685,632	937,409	1,623,041	-435,289	1,187,752	-20,686	1,167,066	16
17	01700	Social Service	139,132	98,170	237,302	-53,537	183,765		183,765	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	81,710	25,257	106,967	-45	106,922	-23,928	82,994	23
23.01	02301	PASTORAL EDUCATION PROGRAM				40,718	40,718	-3,975	36,743	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	235,177	241,919	477,096	14,740	491,836	-83,896	407,940	23.02
INPATIENT ROUTINE SERVICE COST CENTERS										
30	03000	Adults & Pediatrics	9,993,450	6,072,285	16,065,735	-1,899,717	14,166,018	-180,675	13,985,343	30
31	03100	Intensive Care Unit	1,843,817	2,071,090	3,914,907	-382,778	3,532,129		3,532,129	31
34.01	03401	NEONATAL INTENSIVE CARE	3,365,230	1,928,858	5,294,088	-1,650,741	3,643,347	-27,518	3,615,829	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	524,095	258,448	782,543	-33,879	748,664		748,664	34.02
40	04000	Subprovider - IPF	728,560	547,535	1,276,095	-32,075	1,244,020	-27,001	1,217,019	40
43	04300	Nursery				1,712,277	1,712,277		1,712,277	43
ANCILLARY SERVICE COST CENTERS										
50	05000	Operating Room	3,528,529	12,118,559	15,647,088	-7,867,761	7,779,327	-240,920	7,538,407	50
51	05100	Recovery Room	467,335	286,339	753,674	-17,190	736,484		736,484	51
52	05200	Delivery Room & Labor Room	1,203,009	1,374,995	2,578,004	-264,749	2,313,255	-477,230	1,836,025	52
53	05300	Anesthesiology	153,247	1,610,413	1,763,660	-116,970	1,646,690	-799,301	847,389	53
54	05400	Radiology-Diagnostic	1,290,646	1,844,651	3,135,297	-1,066,644	2,068,653	-640	2,068,013	54
55	05500	Radiology-Therapeutic	567,355	676,854	1,244,209	-307,352	936,857		936,857	55
56	05600	Radioisotope	107,785	527,943	635,728	-178,021	457,707		457,707	56
60	06000	Laboratory	2,877,680	6,737,853	9,615,533	-323,276	9,292,257	-4,101,291	5,190,966	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	92,888	652,827	745,715	-91,202	654,513		654,513	63
65	06500	Respiratory Therapy	1,139,009	1,044,778	2,183,787	-284,001	1,899,786	-158	1,899,628	65
66	06600	Physical Therapy	266,818	670,991	937,809	-3,597	934,212		934,212	66
69	06900	Electrocardiology	557,272	453,261	1,010,533	-158,234	852,299		852,299	69
70	07000	Electroencephalography	287,913	278,609	566,522	-94,892	471,630		471,630	70
71	07100	Medical Supplies Charged to Patients				5,148,460	5,148,460		5,148,460	71
72	07200	Impl. Dev. Charged to Patients				7,410,421	7,410,421		7,410,421	72
73	07300	Drugs Charged to Patients				6,019,366	6,019,366		6,019,366	73
74	07400	Renal Dialysis		329,688	329,688	-9,049	320,639		320,639	74
76	03340	GI LAB	237,545	377,674	615,219	-243,939	371,280		371,280	76
76.01	03450	MRI	238,960	445,745	684,705	-225,117	459,588		459,588	76.01
76.02	03290	CT SCAN	317,548	372,157	689,705	-154,786	534,919		534,919	76.02
76.03	03650	CARDIAC CATHETERIZATIN	441,814	2,605,719	3,047,533	-2,247,726	799,807	-61,082	738,725	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	99,228	135,622	234,850	-17,263	217,587		217,587	76.08
76.10	03955	GENETIC SERVICES	374,817	319,323	694,140	-101,553	592,587	-33,408	559,179	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	252,600	302,750	555,350	-193,096	362,254		362,254	90.01
90.02	09001	ANTENATAL TEST CENTER	164,566	240,281	404,847	-31,828	373,019	-376	372,643	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	167,846	60,332	228,178	-469	227,709		227,709	90.03
91	09100	Emergency	2,750,024	2,164,949	4,914,973	-686,556	4,228,417	-49,579	4,178,838	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	35,366	208,593	243,959	-306	243,653	-37,700	205,953	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)	52,735,201	108,888,966	161,624,167	851,984	162,476,151	-29,336,188	133,139,963	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		670,616	670,616	-63	670,553		670,553	192
193.0 1	19301	BELOIT HEART STANDBY	17,371	5,062	22,433		22,433		22,433	193.0 1
194	07950	GUEST CENTER	40,006	160,193	200,199	-3,078	197,121	-59,400	137,721	194
194.0 1	07954	OTHER NONREIMBURSEABLE COST CENTER								194.0 1
194.0 2	07951	COMMUNITY SERVICES	192,397	1,289,373	1,481,770	-847,793	633,977		633,977	194.0 2
194.0 4	07952	AUXILIARY	46,884	121,210	168,094	-1,050	167,044		167,044	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)	53,031,859	111,135,420	164,167,279		164,167,279	-29,395,588	134,771,691	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	4	5	
		A	Drugs Charged to Patients	73		6,019,366	1
500	Total reclassifications					6,019,366	500
	Code Letter - A						
1	EMT MEDICAL DIRECTOR	D	PARAMED EDUC EMT PROGRAM	23.02		15,000	1
500	Total reclassifications					15,000	500
	Code Letter - D						
1	SHARED DIETARY EXPENSES	E	Cafeteria	11	750,539	1,052,201	1
500	Total reclassifications				750,539	1,052,201	500
	Code Letter - E						
1	RECLASS MED SUPPLIES CHGD PAT	F	Medical Supplies Charged to P	71		5,148,460	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					5,148,460	500
	Code Letter - F						
1	NURSERY COSTS	G	Nursery	43	279,262	174,385	1
2			Nursery	43	804,215	454,415	2
500	Total reclassifications				1,083,477	628,800	500
	Code Letter - G						
1	DEPARTMENTAL DEPRECIATION	H	Cap Rel Costs-Mvble Equip	2		7,951,165	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

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			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					7,951,165	500
	Code Letter - H						
1	INSURANCE RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		114,360	1
2							2
3							3
500	Total reclassifications					114,360	500
	Code Letter - I						
1	PASTORAL EDUCATION PROGRAM	J	PASTORAL EDUCATION PROGRAM	23.01	26,538	14,180	1
500	Total reclassifications				26,538	14,180	500
	Code Letter - J						
1	IMPLANTS	K	Impl. Dev. Charged to Patient	72		7,410,421	1
2							2
3							3
500	Total reclassifications					7,410,421	500
	Code Letter - K						
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4		504,014	1
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5		5,745,127	2
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7		73,523	3
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16		240,961	4
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17		22,424	5
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02		125,108	6
500	Total reclassifications					6,711,157	500
	Code Letter - L						
1	SHARED SERVICES DIRECT COST ASSIGNE	M	Cap Rel Costs-Mvble Equip	2		954,141	1
2	SHARED SERVICES DIRECT COST ASSIGNE	M	Administrative & General	5		1,483,702	2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					2,437,843	500
	Code Letter - M						
	GRAND TOTAL (Increases)				1,860,554	37,502,953	

(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		6,019,366	1	
500	Total reclassifications					6,019,366	500	
	Code letter - A							
1	EMT MEDICAL DIRECTOR	D	Administrative & General	5		15,000	1	
500	Total reclassifications					15,000	500	
	Code letter - D							
1	SHARED DIETARY EXPENSES	E	Dietary	10	750,539	1,052,201	1	
500	Total reclassifications				750,539	1,052,201	500	
	Code letter - E							
1	RECLASS MED SUPPLIES CHGD PAT	F					1	
2			Adults & Pediatrics	30		686,210	2	
3			Intensive Care Unit	31		251,291	3	
4			NEONATAL INTENSIVE CARE	34.01		270,245	4	
5			PEDIATRIC INTENSIVE CARE	34.02		24,507	5	
6			Subprovider - IPF	40		2,989	6	
7			Operating Room	50		1,837,048	7	
8			Recovery Room	51		12,811	8	
9			Delivery Room & Labor Room	52		125,584	9	
10			Anesthesiology	53		22,776	10	
11			Radiology-Diagnostic	54		398,651	11	
12			Radiology-Therapeutic	55		24,662	12	
13			Radioisotope	56		176,236	13	
14			Blood Storing, Processing & T	63		81,180	14	
15			Respiratory Therapy	65		200,603	15	
16			Physical Therapy	66		307	16	
17			Electrocardiology	69		36,506	17	
18			Electroencephalography	70		38,362	18	
19			Renal Dialysis	74		5,047	19	
20			GI LAB	76		49,075	20	
21			MRI	76.01		9,597	21	
22			CT SCAN	76.02		52,902	22	
23			CARDIAC CATHETERIZATIN	76.03		242,251	23	
24			SPECIAL SURGICAL SERVICES	76.08		6,109	24	
25			GENETIC SERVICES	76.10		68,569	25	
26			PAIN CENTER	90.01		124,310	26	
27			ANTENATAL TEST CENTER	90.02		5,499	27	
28			CHILD PSYCHIATRIC CLINIC	90.03		311	28	
29			Emergency	91		394,533	29	
30							30	
31			Physicians' Private Offices	192		63	31	
32							32	
33			COMMUNITY SERVICES	194.02		226	33	
500	Total reclassifications					5,148,460	500	
	Code letter - F							
1	NURSERY COSTS	G	Adults & Pediatrics	30	279,262	174,385	1	
2			NEONATAL INTENSIVE CARE	34.01	804,215	454,415	2	
500	Total reclassifications				1,083,477	628,800	500	
	Code letter - G							
1	DEPARTMENTAL DEPRECIATION	H	Employee Benefits Department	4		14,045	9	
2			Administrative & General	5		2,480,043	2	
3			Operation of Plant	7		647,151	3	
4			Laundry & Linen Service	8		3,688	4	
5			Housekeeping	9		12,467	5	
6			Dietary	10		31,150	6	
7			Nursing Administration	13		17,215	7	
8			Central Services & Supply	14		193,374	8	
9			Pharmacy	15		130,752	9	
10			Medical Records & Library	16		5,082	10	
11			PARAMDICAL ED PROGRAM XRAY	23		45	11	
12			PARAMED EDUC EMT PROGRAM	23.02		260	12	
13			Adults & Pediatrics	30		758,810	13	
14			Intensive Care Unit	31		131,487	14	
15			NEONATAL INTENSIVE CARE	34.01		121,866	15	
16			PEDIATRIC INTENSIVE CARE	34.02		9,372	16	
17			Subprovider - IPF	40		29,086	17	
18			Operating Room	50		779,548	18	
19			Recovery Room	51		4,379	19	
20			Delivery Room & Labor Room	52		135,625	20	
21			Anesthesiology	53		94,194	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		377,841	22	
23			Radiology-Therapeutic	55		282,690	23	
24			Radioisotope	56		1,785	24	
25			Laboratory	60		322,973	25	
26			Blood Storing, Processing & T	63		10,022	26	
27			Respiratory Therapy	65		83,398	27	
28			Physical Therapy	66		3,290	28	
29			Electrocardiology	69		121,728	29	
30			Electroencephalography	70		56,530	30	
31			Renal Dialysis	74		4,002	31	
32			GI LAB	76		194,864	32	
33			MRI	76.01		215,520	33	
34			CT SCAN	76.02		101,884	34	
35			CARDIAC CATHETERIZATIN	76.03		136,371	35	
36			SPECIAL SURGICAL SERVICES	76.08		11,154	36	
37			GENETIC SERVICES	76.10		32,984	37	
38			PAIN CENTER	90.01		68,786	38	
39			ANTENATAL TEST CENTER	90.02		26,329	39	
40			CHILD PSYCHIATRIC CLINIC	90.03		158	40	
41			Emergency	91		292,023	41	
42			Ambulance Services	95		306	42	
43			GUEST CENTER	194		3,078	43	
44			COMMUNITY SERVICES	194.02		2,760	44	
45			AUXILIARY	194.04		1,050	45	
500	Total reclassifications					7,951,165	500	
	Code letter - H							
1	INSURANCE RECLASS	I	Administrative & General	5		113,368	9 1	
2			Laboratory	60		261	2	
3			COMMUNITY SERVICES	194.02		731	3	
500	Total reclassifications					114,360	500	
	Code letter - I							
1	PASTORAL EDUCATION PROGRAM	J	Administrative & General	5	26,538	14,180	1	
500	Total reclassifications				26,538	14,180	500	
	Code letter - J							
1	IMPLANTS	K	Operating Room	50		5,251,165	1	
2			Radiology-Diagnostic	54		290,152	2	
3			CARDIAC CATHETERIZATIN	76.03		1,869,104	3	
500	Total reclassifications					7,410,421	500	
	Code letter - K							
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4	504,014		1	
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5	5,745,127		2	
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7	73,523		3	
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16	240,961		4	
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17	22,424		5	
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02	125,108		6	
500	Total reclassifications				6,711,157		500	
	Code letter - L							
1	SHARED SERVICES DIRECT COST ASSIGNE	M	Employee Benefits Department	4		989,470	9 1	
2	SHARED SERVICES DIRECT COST ASSIGNE	M	Operation of Plant	7		115,921	2	
3			Medical Records & Library	16		430,207	3	
4			Social Service	17		53,537	4	
5			Adults & Pediatrics	30		1,050	5	
6			Delivery Room & Labor Room	52		3,540	6	
7			Laboratory	60		42	7	
8			COMMUNITY SERVICES	194.02		844,076	8	
500	Total reclassifications					2,437,843	500	
	Code letter - M							
	GRAND TOTAL (Decreases)				8,571,711	30,791,796		

(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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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	2,600,972					2,600,972		1
2	Land Improvements	7,340,745					7,340,745		2
3	Buildings and Fixtures	54,804,308					54,804,308		3
4	Building Improvements								4
5	Fixed Equipment	119,370,349		3,386,726	3,386,726	252,027	122,505,048		5
6	Movable Equipment	94,236,101		6,989,118	6,989,118	756,910	100,468,309		6
7	HIT-designated Assets	22,809,355		52,500	52,500		22,861,855		7
8	Subtotal (sum of lines 1-7)	301,161,830		10,428,344	10,428,344	1,008,937	310,581,237		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	301,161,830		10,428,344	10,428,344	1,008,937	310,581,237		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	64,746,025		64,746,025	0.209396					1
2	Cap Rel Costs-Mvble Equip	245,835,212	1,378,000	244,457,212	0.790604					2
3	Total (sum of lines 1-2)	310,581,237	1,378,000	309,203,237	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	113,409						113,409	1	
2	Cap Rel Costs-Mvble Equip	8,841,116						8,841,116	2	
3	Total (sum of lines 1-2)	8,954,525						8,954,525	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	Trade, quantity, and time discounts (chapter 8)					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	-4,787	Administrative & General	5	8	
9	Parking lot (chapter 21)					9	
10	Provider-based physician adjustment	Wkst A-8-2	-18,782,782			10	
11	Sale of scrap, waste, etc. (chapter 23)					11	
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,584,143			12	
13	Laundry and linen service					13	
14	Cafeteria - employees and guests	B	-800,307	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	-20,686	Medical Records & Library	16	18	
19	Nursing school (tuition,fees,books,etc.)					19	
20	Vending machines	B	-86,706	Cafeteria	11	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	MISC REV - EMP BEN	B	-674,252	Employee Benefits Department	4	33.01	
33.02	MISC REV - ADMIN	B	-171,720	Administrative & General	5	33.02	
33.03	MISC REV - PLANT	B	-13,028	Operation of Plant	7	33.03	
33.04	MISC REV - NURSE ADMIN	B	-9,245	Nursing Administration	13	33.04	
33.05	MISC REV - PARAMED XRAY ED	B	-23,928	PARAMEDICAL ED PROGRAM XRAY	23	33.05	
33.06	MISC REV - PASTORAL ED	B	-3,975	PASTORAL EDUCATION PROGRAM	23.01	33.06	
33.07	MISC REV - PARAMED EMT ED	B	-83,896	PARAMED EDUC EMT PROGRAM	23.02	33.07	
33.08	MISC REV - NICU	B	-7,970	NEONATAL INTENSIVE CARE	34.01	33.08	
33.09	MISC REV - XRAYS	B	-640	Radiology-Diagnostic	54	33.09	
33.10	MISC REV - REF LAB	B	-3,907,277	Laboratory	60	33.10	
33.11	MISC REV - RESP	B	-158	Respiratory Therapy	65	33.11	
33.12	MISC REV - CYTOGENETICS	B	-33,408	GENETIC SERVICES	76.10	33.12	
33.13	MISC REV - EMERG	B	-16,133	Emergency	91	33.13	
33.14	MISC REV - LEASE	B	-13,200	Ambulance Services	95	33.14	
33.15	MISC REV - AMBULANCE	B	-4,500	Ambulance Services	95	33.15	
34						34	
34.01	INTEREST - ADMIN	A	-628,535	Administrative & General	5	34.01	
34.02	INTEREST - SURG	A	-25,125	Operating Room	50	34.02	
35						35	
35.01	PATIENT PHONE - BLD & FIXT	A	-951	Cap Rel Costs-Bldg & Fixt	1	9	35.01
35.02	PATIENT PHONE - EQUIP	A	-5,242	Cap Rel Costs-Mvble Equip	2	9	35.02
35.03	PATIENT PHONE - EMP BEN	A	-1,203	Employee Benefits Department	4		35.03
35.04	PATIENT PHONE - ADMIN	A	-58,348	Administrative & General	5		35.04
35.05	PATIENT PHONE - PLANT	A	-162,913	Operation of Plant	7		35.05
35.06	PATIENT PHONE - HOUSEKEEP	A	-47,826	Housekeeping	9		35.06
36						36	
36.01	PHYSICIAN BILLING	A	-445	Administrative & General	5		36.01
37						37	
37.01	LOBBYING	A	-19,455	Administrative & General	5		37.01
38						38	
39						39	

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

			EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
39.01	TAXES - PROV ASSESS	A	-6,311,690	Administrative & General	5		39.01
39.02	TAXES - PROPERTY	A	-59,400	GUEST CENTER	194		39.02
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-29,395,588				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	2	Cap Rel Costs-Mvble Equip	SHARED SERVICES - DEPR	895,193	954,141	-58,948	9
2	5	Administrative & General	MNGMT FEE & SHARED SVCS	18,992,939	16,349,848	2,643,091	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			19,888,132	17,303,989	2,584,143	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				SERVICE	6
7	E	RMHSC				PHYSICIAN CLINI	7
8	E	FREEPORT MEM HO				MOBILE CATH LAB	8
9	B	ROCKFORD HEALTH SYSTEM				HOME OFFICE	9
10	B	VAN MATER REHAB HOSPITAL		VAN MATER REHAB HOSPITAL		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 Remun- eration	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	1,118	1,118		171,400				1
2	5	Administrative & Gen PROFESSIONAL FE	17,932,187	16,682,553	1,249,634	171,400	29,644	2,442,780	122,139	2
3	13	Nursing Administrati PROFESSIONAL FE	70,741	69,940	801	204,100	1	98	5	3
4	17	Social Service PROFESSIONAL FE								4
5	30	Adults & Pediatrics PROFESSIONAL FE	200,038	50,707	149,331	179,000	225	19,363	968	5
6	31	Intensive Care Unit PROFESSIONAL FE								6
7	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE	36,449		36,449	197,500	178	16,901	845	7
8	34.02	PEDIATRIC INTENSIVE PROFESSIONAL FE	4,800		4,800	197,500	73	6,931	347	8
9	40	Subprovider - IPF PROFESSIONAL FE	41,383		41,383	181,300	165	14,382	719	9
10	50	Operating Room PROFESSIONAL FE	833,435	215,795	617,640	246,400	7,104	841,551	42,078	10
11	52	Delivery Room & Labo PROFESSIONAL FE	501,510		501,510	237,100	213	24,280	1,214	11
12	53	Anesthesiology PROFESSIONAL FE	828,190	777,618	50,572	239,400	251	28,889	1,444	12
13	60	Laboratory PROFESSIONAL FE	194,014	194,014		260,300				13
14	65	Respiratory Therapy PROFESSIONAL FE	3,600		3,600	197,500	49	4,653	233	14
15	70	Electroencephalograp PROFESSIONAL FE	4,800		4,800	271,900	43	5,621	281	15
16	76.03	CARDIAC CATHETERIZAT PROFESSIONAL FE	61,082	61,082		271,900				16
17	90.02	ANTENATAL TEST CENTE PROFESSIONAL FE	376	376		271,900				17
18	91	Emergency PROFESSIONAL FE	123,870		123,870	200,300	939	90,424	4,521	18
19	95	Ambulance Services PROFESSIONAL FE	20,000	20,000		200,300				19
20										20
200		TOTAL	20,857,593	18,073,203	2,784,390		38,885	3,495,873	174,794	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						1,118	1
2	5	Administrative & Gen	PROFESSIONAL FE				2,442,780		16,682,553	2
3	13	Nursing Administrati	PROFESSIONAL FE				98	703	70,643	3
4	17	Social Service	PROFESSIONAL FE							4
5	30	Adults & Pediatrics	PROFESSIONAL FE				19,363	129,968	180,675	5
6	31	Intensive Care Unit	PROFESSIONAL FE							6
7	34.01	NEONATAL INTENSIVE C	PROFESSIONAL FE				16,901	19,548	19,548	7
8	34.02	PEDIATRIC INTENSIVE	PROFESSIONAL FE				6,931			8
9	40	Subprovider - IPF	PROFESSIONAL FE				14,382	27,001	27,001	9
10	50	Operating Room	PROFESSIONAL FE				841,551		215,795	10
11	52	Delivery Room & Labo	PROFESSIONAL FE				24,280	477,230	477,230	11
12	53	Anesthesiology	PROFESSIONAL FE				28,889	21,683	799,301	12
13	60	Laboratory	PROFESSIONAL FE						194,014	13
14	65	Respiratory Therapy	PROFESSIONAL FE				4,653			14
15	70	Electroencephalograp	PROFESSIONAL FE				5,621			15
16	76.03	CARDIAC CATHETERIZAT	PROFESSIONAL FE						61,082	16
17	90.02	ANTENATAL TEST CENTE	PROFESSIONAL FE						376	17
18	91	Emergency	PROFESSIONAL FE				90,424	33,446	33,446	18
19	95	Ambulance Services	PROFESSIONAL FE						20,000	19
20										20
200		TOTAL					3,495,873	709,579	18,782,782	200

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	113,409	113,409					1
2	Cap Rel Costs-Mvble Equip	8,841,116		8,841,116				2
4	Employee Benefits Department	402,191	3,185	26,887	432,263			4
5	Administrative & General	29,140,322	30,662	3,375,690	30,762	32,577,436	32,577,436	5
6	Maintenance & Repairs							6
7	Operation of Plant	5,831,520	11,924	657,246	11,305	6,511,995	2,075,894	7
8	Laundry & Linen Service	545,244	627	3,654	467	549,992	175,326	8
9	Housekeeping	1,696,704	1,358	12,353	8,789	1,719,204	548,048	9
10	Dietary	839,683	1,681	30,864	3,400	875,628	279,133	10
11	Cafeteria	915,727	3,480		7,039	926,246	295,269	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,194,645	960	17,057	14,824	2,227,486	710,078	13
14	Central Services & Supply	1,604,307	1,854	191,599	6,106	1,803,866	575,036	14
15	Pharmacy	2,773,635	1,082	129,552	17,665	2,921,934	931,454	15
16	Medical Records & Library	1,167,066	809	10,284	6,430	1,184,589	377,623	16
17	Social Service	183,765	266		1,094	185,125	59,014	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	82,994	96	45	766	83,901	26,746	23
23.01	PASTORAL EDUCATION PROGRAM	36,743	71		249	37,063	11,815	23.01
23.02	PARAMED EDUC EMT PROGRAM	407,940	827	258	2,205	411,230	131,092	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	13,985,343	16,877	751,846	91,096	14,845,162	4,732,293	30
31	Intensive Care Unit	3,532,129	1,435	130,280	17,291	3,681,135	1,173,472	31
34.01	NEONATAL INTENSIVE CARE	3,615,829	1,917	120,748	24,017	3,762,511	1,199,413	34.01
34.02	PEDIATRIC INTENSIVE CARE	748,664	524	9,286	4,915	763,389	243,353	34.02
40	Subprovider - IPF	1,217,019	1,599	28,819	6,832	1,254,269	399,836	40
43	Nursery	1,712,277	1,165		10,161	1,723,603	549,450	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	7,538,407	5,929	772,393	33,091	8,349,820	2,661,756	50
51	Recovery Room	736,484	462	4,339	4,383	745,668	237,704	51
52	Delivery Room & Labor Room	1,836,025	2,016	134,380	11,282	1,983,703	632,365	52
53	Anesthesiology	847,389	133	93,329	1,437	942,288	300,383	53
54	Radiology-Diagnostic	2,068,013	1,683	371,004	12,104	2,452,804	781,905	54
55	Radiology-Therapeutic	936,857	1,927	280,095	5,321	1,224,200	390,250	55
56	Radioisotope	457,707	210	1,769	1,011	460,697	146,861	56
60	Laboratory	5,190,966	2,383	320,009	26,987	5,540,345	1,766,151	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	654,513	107	9,930	871	665,421	212,123	63
65	Respiratory Therapy	1,899,628	1,588	82,633	10,682	1,994,531	635,817	65
66	Physical Therapy	934,212	793	3,260	2,502	940,767	299,898	66
69	Electrocardiology	852,299	1,226	120,611	5,226	979,362	312,201	69
70	Electroencephalography	471,630	76	56,011	2,700	530,417	169,086	70
71	Medical Supplies Charged to Patients	5,148,460				5,148,460	1,641,226	71
72	Impl. Dev. Charged to Patients	7,410,421				7,410,421	2,362,294	72
73	Drugs Charged to Patients	6,019,366				6,019,366	1,918,853	73
74	Renal Dialysis	320,639	253	3,965		324,857	103,558	74
76	GI LAB	371,280	1,178	193,076	2,228	567,762	180,991	76
76.01	MRI	459,588	842	213,542	2,241	676,213	215,563	76.01
76.02	CT SCAN	534,919	426	100,949	2,978	639,272	203,787	76.02
76.03	CARDIAC CATHETERIZATIN	738,725	803	135,119	4,143	878,790	280,141	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	217,587	510	11,052	931	230,080	73,345	76.08
76.10	GENETIC SERVICES	559,179	846	32,681	3,515	596,221	190,063	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	362,254	827	68,155	2,369	433,605	138,225	90.01
90.02	ANTENATAL TEST CENTER	372,643	778	26,087	1,543	401,051	127,847	90.02
90.03	CHILD PSYCHIATRIC CLINIC	227,709	245	157	1,574	229,685	73,219	90.03
91	Emergency	4,178,838	2,449	289,343	25,790	4,496,420	1,433,369	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	205,953	872	303	332	207,460	66,134	95

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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)	133,139,963	110,961	8,820,660	430,654	133,115,450	32,049,460	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	670,553	78			670,631	213,784	192
193.0 1	BELOIT HEART STANDBY	22,433			163	22,596	7,203	193.0 1
194	GUEST CENTER	137,721	762	3,050	375	141,908	45,237	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	633,977	77	16,366	631	651,051	207,542	194.0 2
194.0 4	AUXILIARY	167,044	1,531	1,040	440	170,055	54,210	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)	134,771,691	113,409	8,841,116	432,263	134,771,691	32,577,436	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	8,587,889						7
8	Laundry & Linen Service	79,668	804,986					8
9	Housekeeping	172,425		2,439,677				9
10	Dietary	213,450		62,472	1,430,683			10
11	Cafeteria	441,881		129,327		1,792,723		11
12	Maintenance of Personnel							12
13	Nursing Administration	121,904		35,678		42,381	3,137,527	13
14	Central Services & Supply	235,334	4,497	68,876		53,683		14
15	Pharmacy	137,338		40,195		63,572		15
16	Medical Records & Library	102,706		30,059		22,603		16
17	Social Service	33,743		9,876		5,651		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	12,238		3,582		18,365		23
23.01	PASTORAL EDUCATION PROGRAM	8,984		2,630				23.01
23.02	PARAMED EDUC EMT PROGRAM	104,957		30,718		11,302	30,724	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	2,142,827	293,345	627,151	1,140,395	476,083	1,331,375	30
31	Intensive Care Unit	182,166	26,690	53,315	125,977	81,937	231,203	31
34.01	NEONATAL INTENSIVE CARE	243,373	25,327	71,229		100,302	280,163	34.01
34.02	PEDIATRIC INTENSIVE CARE	66,579		19,486	35,961	21,191	57,471	34.02
40	Subprovider - IPF	202,972	7,125	59,405	103,635	36,730		40
43	Nursery	147,949	4,335	43,301		53,683		43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	752,817	138,207	220,330		137,032	382,031	50
51	Recovery Room	58,692	6,528	17,178		15,540	45,162	51
52	Delivery Room & Labor Room	255,970	43,206	74,916		50,857	141,945	52
53	Anesthesiology	16,891		4,943		8,476	21,925	53
54	Radiology-Diagnostic	213,696	29,844	62,543		59,334		54
55	Radiology-Therapeutic	244,621	3,637	71,595		21,191		55
56	Radioisotope	26,651	25	7,800		4,238		56
60	Laboratory	302,519	7,765	88,540		162,461		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	13,618		3,986		4,238		63
65	Respiratory Therapy	201,648	132	59,017		53,683		65
66	Physical Therapy	100,663	367	29,462		9,889		66
69	Electrocardiology	155,629		45,549		24,016	68,896	69
70	Electroencephalography	9,684		2,834		12,714	37,561	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	32,136		9,405				74
76	GI LAB	149,557	11,882	43,772		9,889	28,177	76
76.01	MRI	106,867	7,102	31,277		9,889		76.01
76.02	CT SCAN	54,114		15,838		14,127		76.02
76.03	CARDIAC CATHETERIZATIN	101,892	9,525	29,821		18,365	49,697	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	64,707	8,002	18,938		4,238	12,293	76.08
76.10	GENETIC SERVICES	107,472	144	31,454		12,714		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	105,032		30,740		14,127	37,855	90.01
90.02	ANTENATAL TEST CENTER	98,828	6,912	28,925		7,064	18,928	90.02
90.03	CHILD PSYCHIATRIC CLINIC	31,133	223	9,112		4,238	13,708	90.03
91	Emergency	310,992	166,577	91,020	24,715	122,905	344,757	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	110,763		32,418		1,413	3,656	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 ADMINIS- TRATION	
		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)	8,277,086	801,397	2,348,713	1,430,683	1,782,835	3,137,527	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	9,892		2,895				192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER	96,804	3,589	28,332		2,825		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	9,779		2,862		2,825		194.0 2
194.0 4	AUXILIARY	194,328		56,875		4,238		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)	8,587,889	804,986	2,439,677	1,430,683	1,792,723	3,137,527	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	2,741,292						14
15	Pharmacy		4,094,493					15
16	Medical Records & Library			1,717,580				16
17	Social Service				293,409			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					144,832		23
23.01	PASTORAL EDUCATION PROGRAM						73,206	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			104,158	249,891		46,202	30
31	Intensive Care Unit			24,977			5,104	31
34.01	NEONATAL INTENSIVE CARE			62,895	3,827		13,362	34.01
34.02	PEDIATRIC INTENSIVE CARE			8,819	1,088		1,457	34.02
40	Subprovider - IPF			8,205	36,465		4,199	40
43	Nursery			26,783	2,138		2,882	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			115,118				50
51	Recovery Room			14,017				51
52	Delivery Room & Labor Room			29,004				52
53	Anesthesiology		84,690	21,267				53
54	Radiology-Diagnostic			76,073		144,832		54
55	Radiology-Therapeutic			19,940				55
56	Radioisotope			15,869				56
60	Laboratory			116,862				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			19,081				63
65	Respiratory Therapy			50,385				65
66	Physical Therapy			12,195				66
69	Electrocardiology			56,059				69
70	Electroencephalography			16,141				70
71	Medical Supplies Charged to Patients	1,118,346		257,226				71
72	Impl. Dev. Charged to Patients	1,622,946		148,538				72
73	Drugs Charged to Patients		4,009,803	200,124				73
74	Renal Dialysis			2,342				74
76	GI LAB			12,576				76
76.01	MRI			43,055				76.01
76.02	CT SCAN			83,640				76.02
76.03	CARDIAC CATHETERIZATIN			39,833				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			4,005				76.08
76.10	GENETIC SERVICES			1,633				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			14,721				90.01
90.02	ANTENATAL TEST CENTER			14,223				90.02
90.03	CHILD PSYCHIATRIC CLINIC			555				90.03
91	Emergency			96,382				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			825				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)	2,741,292	4,094,493	1,717,526	293,409	144,832	73,206	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			54				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)	2,741,292	4,094,493	1,717,580	293,409	144,832	73,206	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT 23.02	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 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	720,023					23.02
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,126	26,008,008		26,008,008		30
31	Intensive Care Unit		5,585,976		5,585,976		31
34.01	NEONATAL INTENSIVE CARE	38,251	5,800,653		5,800,653		34.01
34.02	PEDIATRIC INTENSIVE CARE		1,218,794		1,218,794		34.02
40	Subprovider - IPF		2,112,841		2,112,841		40
43	Nursery		2,554,124		2,554,124		43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	100,128	12,857,239		12,857,239		50
51	Recovery Room		1,140,489		1,140,489		51
52	Delivery Room & Labor Room	19,126	3,231,092		3,231,092		52
53	Anesthesiology		1,400,863		1,400,863		53
54	Radiology-Diagnostic		3,821,031		3,821,031		54
55	Radiology-Therapeutic		1,975,434		1,975,434		55
56	Radioisotope		662,141		662,141		56
60	Laboratory		7,984,643		7,984,643		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		918,467		918,467		63
65	Respiratory Therapy	14,625	3,009,838		3,009,838		65
66	Physical Therapy		1,393,241		1,393,241		66
69	Electrocardiology		1,641,712		1,641,712		69
70	Electroencephalography		778,437		778,437		70
71	Medical Supplies Charged to Patients		8,165,258		8,165,258		71
72	Impl. Dev. Charged to Patients		11,544,199		11,544,199		72
73	Drugs Charged to Patients		12,148,146		12,148,146		73
74	Renal Dialysis		472,298		472,298		74
76	GI LAB		1,004,606		1,004,606		76
76.01	MRI		1,089,966		1,089,966		76.01
76.02	CT SCAN		1,010,778		1,010,778		76.02
76.03	CARDIAC CATHETERIZATIN		1,408,064		1,408,064		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		415,608		415,608		76.08
76.10	GENETIC SERVICES		939,701		939,701		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		774,305		774,305		90.01
90.02	ANTENATAL TEST CENTER		703,778		703,778		90.02
90.03	CHILD PSYCHIATRIC CLINIC		361,873		361,873		90.03
91	Emergency	528,767	7,615,904		7,615,904		91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		422,669		422,669		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	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)	720,023	132,172,176		132,172,176		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		897,202		897,202		192
193.0 1	BELOIT HEART STANDBY		29,799		29,799		193.0 1
194	GUEST CENTER		318,695		318,695		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER						194.0 1
194.0 2	COMMUNITY SERVICES		874,113		874,113		194.0 2
194.0 4	AUXILIARY		479,706		479,706		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)	720,023	134,771,691		134,771,691		202

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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		3,185	26,887	30,072	30,072		4
5	Administrative & General		30,662	3,375,690	3,406,352	2,139	3,408,491	5
6	Maintenance & Repairs							6
7	Operation of Plant		11,924	657,246	669,170	786	217,195	7
8	Laundry & Linen Service		627	3,654	4,281	32	18,344	8
9	Housekeeping		1,358	12,353	13,711	611	57,341	9
10	Dietary		1,681	30,864	32,545	236	29,205	10
11	Cafeteria		3,480		3,480	489	30,893	11
12	Maintenance of Personnel							12
13	Nursing Administration		960	17,057	18,017	1,031	74,293	13
14	Central Services & Supply		1,854	191,599	193,453	424	60,164	14
15	Pharmacy		1,082	129,552	130,634	1,228	97,455	15
16	Medical Records & Library		809	10,284	11,093	447	39,510	16
17	Social Service		266		266	76	6,174	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		96	45	141	53	2,798	23
23.01	PASTORAL EDUCATION PROGRAM		71		71	17	1,236	23.01
23.02	PARAMED EDUC EMT PROGRAM		827	258	1,085	153	13,716	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		16,877	751,846	768,723	6,354	495,134	30
31	Intensive Care Unit		1,435	130,280	131,715	1,202	122,777	31
34.01	NEONATAL INTENSIVE CARE		1,917	120,748	122,665	1,670	125,491	34.01
34.02	PEDIATRIC INTENSIVE CARE		524	9,286	9,810	342	25,461	34.02
40	Subprovider - IPF		1,599	28,819	30,418	475	41,834	40
43	Nursery		1,165		1,165	706	57,487	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,929	772,393	778,322	2,301	278,492	50
51	Recovery Room		462	4,339	4,801	305	24,870	51
52	Delivery Room & Labor Room		2,016	134,380	136,396	784	66,162	52
53	Anesthesiology		133	93,329	93,462	100	31,428	53
54	Radiology-Diagnostic		1,683	371,004	372,687	842	81,808	54
55	Radiology-Therapeutic		1,927	280,095	282,022	370	40,831	55
56	Radioisotope		210	1,769	1,979	70	15,366	56
60	Laboratory		2,383	320,009	322,392	1,876	184,787	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		107	9,930	10,037	61	22,194	63
65	Respiratory Therapy		1,588	82,633	84,221	743	66,524	65
66	Physical Therapy		793	3,260	4,053	174	31,377	66
69	Electrocardiology		1,226	120,611	121,837	363	32,665	69
70	Electroencephalography		76	56,011	56,087	188	17,691	70
71	Medical Supplies Charged to Patients						171,717	71
72	Impl. Dev. Charged to Patients						247,160	72
73	Drugs Charged to Patients						200,764	73
74	Renal Dialysis		253	3,965	4,218		10,835	74
76	GI LAB		1,178	193,076	194,254	155	18,937	76
76.01	MRI		842	213,542	214,384	156	22,554	76.01
76.02	CT SCAN		426	100,949	101,375	207	21,322	76.02
76.03	CARDIAC CATHETERIZATIN		803	135,119	135,922	288	29,310	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		510	11,052	11,562	65	7,674	76.08
76.10	GENETIC SERVICES		846	32,681	33,527	244	19,886	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		827	68,155	68,982	165	14,462	90.01
90.02	ANTENATAL TEST CENTER		778	26,087	26,865	107	13,376	90.02
90.03	CHILD PSYCHIATRIC CLINIC		245	157	402	109	7,661	90.03
91	Emergency		2,449	289,343	291,792	1,793	149,969	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		872	303	1,175	23	6,919	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)		110,961	8,820,660	8,931,621	29,960	3,353,249	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		78		78		22,368	192
193.0 1	BELOIT HEART STANDBY					11	754	193.0 1
194	GUEST CENTER		762	3,050	3,812	26	4,733	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES		77	16,366	16,443	44	21,715	194.0 2
194.0 4	AUXILIARY		1,531	1,040	2,571	31	5,672	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)		113,409	8,841,116	8,954,525	30,072	3,408,491	202

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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	887,151						7
8	Laundry & Linen Service	8,230	30,887					8
9	Housekeeping	17,812		89,475				9
10	Dietary	22,050		2,291	86,327			10
11	Cafeteria	45,647		4,743		85,252		11
12	Maintenance of Personnel							12
13	Nursing Administration	12,593		1,308		2,015	109,257	13
14	Central Services & Supply	24,311	173	2,526		2,553		14
15	Pharmacy	14,187		1,474		3,023		15
16	Medical Records & Library	10,610		1,102		1,075		16
17	Social Service	3,486		362		269		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	1,264		131		873		23
23.01	PASTORAL EDUCATION PROGRAM	928		96		605		23.01
23.02	PARAMED EDUC EMT PROGRAM	10,842		1,127		537	1,070	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	221,360	11,256	23,003	68,812	22,637	46,364	30
31	Intensive Care Unit	18,818	1,024	1,955	7,601	3,896	8,051	31
34.01	NEONATAL INTENSIVE CARE	25,141	972	2,612		4,770	9,756	34.01
34.02	PEDIATRIC INTENSIVE CARE	6,878		715	2,170	1,008	2,001	34.02
40	Subprovider - IPF	20,967	273	2,179	6,253	1,747		40
43	Nursery	15,284	166	1,588		2,553		43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	77,768	5,303	8,081		6,517	13,303	50
51	Recovery Room	6,063	250	630		739	1,573	51
52	Delivery Room & Labor Room	26,442	1,658	2,748		2,418	4,943	52
53	Anesthesiology	1,745		181		403	763	53
54	Radiology-Diagnostic	22,075	1,145	2,294		2,822		54
55	Radiology-Therapeutic	25,270	140	2,626		1,008		55
56	Radioisotope	2,753	1	286		202		56
60	Laboratory	31,251	298	3,247		7,726		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,407		146		202		63
65	Respiratory Therapy	20,831	5	2,164		2,553		65
66	Physical Therapy	10,399	14	1,080		470		66
69	Electrocardiology	16,077		1,670		1,142	2,399	69
70	Electroencephalography	1,000		104		605	1,308	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	3,320		345				74
76	GI LAB	15,450	456	1,605		470	981	76
76.01	MRI	11,040	272	1,147		470		76.01
76.02	CT SCAN	5,590		581		672		76.02
76.03	CARDIAC CATHETERIZATIN	10,526	365	1,094		873	1,731	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	6,684	307	695		202	428	76.08
76.10	GENETIC SERVICES	11,102	6	1,154		605		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	10,850		1,127		672	1,318	90.01
90.02	ANTENATAL TEST CENTER	10,209	265	1,061		336	659	90.02
90.03	CHILD PSYCHIATRIC CLINIC	3,216	9	334		202	477	90.03
91	Emergency	32,126	6,391	3,338	1,491	5,845	12,005	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	11,442		1,189		67	127	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		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)	855,044	30,749	86,139	86,327	84,782	109,257	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,022		106				192
193.0 1	BELOIT HEART STANDBY							193.0 1
194	GUEST CENTER	10,000	138	1,039		134		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	1,010		105		134		194.0 2
194.0 4	AUXILIARY	20,075		2,086		202		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)	887,151	30,887	89,475	86,327	85,252	109,257	202

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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	
	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	283,604						14
15	Pharmacy		248,001					15
16	Medical Records & Library			63,837				16
17	Social Service				10,633			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					5,260		23
23.01	PASTORAL EDUCATION PROGRAM						2,953	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			3,857	9,057			30
31	Intensive Care Unit			925				31
34.01	NEONATAL INTENSIVE CARE			2,329	139			34.01
34.02	PEDIATRIC INTENSIVE CARE			327	39			34.02
40	Subprovider - IPF			304	1,321			40
43	Nursery			992	77			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			4,262				50
51	Recovery Room			519				51
52	Delivery Room & Labor Room			1,074				52
53	Anesthesiology		5,130	787				53
54	Radiology-Diagnostic			2,817				54
55	Radiology-Therapeutic			738				55
56	Radioisotope			588				56
60	Laboratory			4,327				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			706				63
65	Respiratory Therapy			1,866				65
66	Physical Therapy			452				66
69	Electrocardiology			2,076				69
70	Electroencephalography			598				70
71	Medical Supplies Charged to Patients	115,701		9,761				71
72	Impl. Dev. Charged to Patients	167,903		5,500				72
73	Drugs Charged to Patients		242,871	7,410				73
74	Renal Dialysis			87				74
76	GI LAB			466				76
76.01	MRI			1,594				76.01
76.02	CT SCAN			3,097				76.02
76.03	CARDIAC CATHETERIZATIN			1,475				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			148				76.08
76.10	GENETIC SERVICES			60				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			545				90.01
90.02	ANTENATAL TEST CENTER			527				90.02
90.03	CHILD PSYCHIATRIC CLINIC			21				90.03
91	Emergency			3,569				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			31				95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	283,604	248,001	63,835	10,633			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			2				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					5,260	2,953	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	283,604	248,001	63,837	10,633	5,260	2,953	202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT 23.02	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 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	28,530					23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		1,676,557		1,676,557		30
31	Intensive Care Unit		297,964		297,964		31
34.01	NEONATAL INTENSIVE CARE		295,545		295,545		34.01
34.02	PEDIATRIC INTENSIVE CARE		48,751		48,751		34.02
40	Subprovider - IPF		105,771		105,771		40
43	Nursery		80,018		80,018		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		1,174,349		1,174,349		50
51	Recovery Room		39,750		39,750		51
52	Delivery Room & Labor Room		242,625		242,625		52
53	Anesthesiology		133,999		133,999		53
54	Radiology-Diagnostic		486,490		486,490		54
55	Radiology-Therapeutic		353,005		353,005		55
56	Radioisotope		21,245		21,245		56
60	Laboratory		555,904		555,904		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		34,753		34,753		63
65	Respiratory Therapy		178,907		178,907		65
66	Physical Therapy		48,019		48,019		66
69	Electrocardiology		178,229		178,229		69
70	Electroencephalography		77,581		77,581		70
71	Medical Supplies Charged to Patients		297,179		297,179		71
72	Impl. Dev. Charged to Patients		420,563		420,563		72
73	Drugs Charged to Patients		451,045		451,045		73
74	Renal Dialysis		18,805		18,805		74
76	GI LAB		232,774		232,774		76
76.01	MRI		251,617		251,617		76.01
76.02	CT SCAN		132,844		132,844		76.02
76.03	CARDIAC CATHETERIZATIN		181,584		181,584		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		27,765		27,765		76.08
76.10	GENETIC SERVICES		66,584		66,584		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		98,121		98,121		90.01
90.02	ANTENATAL TEST CENTER		53,405		53,405		90.02
90.03	CHILD PSYCHIATRIC CLINIC		12,431		12,431		90.03
91	Emergency		508,319		508,319		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services		20,973		20,973		95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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		
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)		8,803,471		8,803,471		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		23,574		23,574		192
193.0 1	BELOIT HEART STANDBY		765		765		193.0 1
194	GUEST CENTER		19,882		19,882		194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER						194.0 1
194.0 2	COMMUNITY SERVICES		39,453		39,453		194.0 2
194.0 4	AUXILIARY		30,637		30,637		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	28,530	36,743		36,743		200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	28,530	8,954,525		8,954,525		202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	761,255						1
2	Cap Rel Costs-Mvble Equip		8,923,010					2
4	Employee Benefits Department	21,381	27,136	46,093,574				4
5	Administrative & General	205,798	3,406,959	3,280,257	-32,577,436	102,194,255		5
6	Maintenance & Repairs							6
7	Operation of Plant	80,039	663,334	1,205,461		6,511,995	454,037	7
8	Laundry & Linen Service	4,212	3,688	49,780		549,992	4,212	8
9	Housekeeping	9,116	12,467	937,235		1,719,204	9,116	9
10	Dietary	11,285	31,150	362,556		875,628	11,285	10
11	Cafeteria	23,362		750,539		926,246	23,362	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,445	17,215	1,580,721		2,227,486	6,445	13
14	Central Services & Supply	12,442	193,374	651,065		1,803,866	12,442	14
15	Pharmacy	7,261	130,752	1,883,692		2,921,934	7,261	15
16	Medical Records & Library	5,430	10,379	685,632		1,184,589	5,430	16
17	Social Service	1,784		116,708		185,125	1,784	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	45	81,710		83,901	647	23
23.01	PASTORAL EDUCATION PROGRAM	475		26,538		37,063	475	23.01
23.02	PARAMED EDUC EMT PROGRAM	5,549	260	235,177		411,230	5,549	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,290	758,810	9,714,188		14,845,162	113,290	30
31	Intensive Care Unit	9,631	131,487	1,843,817		3,681,135	9,631	31
34.01	NEONATAL INTENSIVE CARE	12,867	121,866	2,561,015		3,762,511	12,867	34.01
34.02	PEDIATRIC INTENSIVE CARE	3,520	9,372	524,096		763,389	3,520	34.02
40	Subprovider - IPF	10,731	29,086	728,560		1,254,269	10,731	40
43	Nursery	7,822		1,083,476		1,723,603	7,822	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39,801	779,548	3,528,529		8,349,820	39,801	50
51	Recovery Room	3,103	4,379	467,335		745,668	3,103	51
52	Delivery Room & Labor Room	13,533	135,625	1,203,009		1,983,703	13,533	52
53	Anesthesiology	893	94,194	153,247		942,288	893	53
54	Radiology-Diagnostic	11,298	374,441	1,290,646		2,452,804	11,298	54
55	Radiology-Therapeutic	12,933	282,690	567,355		1,224,200	12,933	55
56	Radioisotope	1,409	1,785	107,785		460,697	1,409	56
60	Laboratory	15,994	322,973	2,877,680		5,540,345	15,994	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	720	10,022	92,888		665,421	720	63
65	Respiratory Therapy	10,661	83,398	1,139,009		1,994,531	10,661	65
66	Physical Therapy	5,322	3,290	266,818		940,767	5,322	66
69	Electrocardiology	8,228	121,728	557,272		979,362	8,228	69
70	Electroencephalography	512	56,530	287,913		530,417	512	70
71	Medical Supplies Charged to Patients					5,148,460		71
72	Impl. Dev. Charged to Patients					7,410,421		72
73	Drugs Charged to Patients					6,019,366		73
74	Renal Dialysis	1,699	4,002	324,857		324,857	1,699	74
76	GI LAB	7,907	194,864	237,545		567,762	7,907	76
76.01	MRI	5,650	215,520	238,960		676,213	5,650	76.01
76.02	CT SCAN	2,861	101,884	317,548		639,272	2,861	76.02
76.03	CARDIAC CATHETERIZATIN	5,387	136,371	441,814		878,790	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	11,154	99,228		230,080	3,421	76.08
76.10	GENETIC SERVICES	5,682	32,984	374,817		596,221	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	5,553	68,786	252,600		433,605	5,553	90.01
90.02	ANTENATAL TEST CENTER	5,225	26,329	164,566		401,051	5,225	90.02
90.03	CHILD PSYCHIATRIC CLINIC	1,646	158	167,846		229,685	1,646	90.03
91	Emergency	16,442	292,023	2,750,024		4,496,420	16,442	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	5,856	306	35,366		207,460	5,856	95
99.10	CORF							99.10

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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)	744,823	8,902,364	45,922,023	-32,577,436	100,538,014	437,605	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	523				670,631	523	192
193.0 1	BELOIT HEART STANDBY			17,371		22,596		193.0 1
194	GUEST CENTER	5,118	3,078	40,006		141,908	5,118	194
194.0 1	OTHER NONREIMBURSEABLE COST CENTER							194.0 1
194.0 2	COMMUNITY SERVICES	517	16,518	67,290		651,051	517	194.0 2
194.0 4	AUXILIARY	10,274	1,050	46,884		170,055	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)	113,409	8,841,116	432,263		32,577,436	8,587,889	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.148976	0.990822	0.009378		0.318780	18.914514	203
204	Cost to be allocated (Per Wkst. B, Part II)			30,072		3,408,491	887,151	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000652		0.033353	1.953918	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	318,280						8
9	Housekeeping		440,709					9
10	Dietary		11,285	94,647				10
11	Cafeteria		23,362		1,269			11
12	Maintenance of Personnel							12
13	Nursing Administration		6,445		30	820,536		13
14	Central Services & Supply	1,778	12,442		38		12,516,840	14
15	Pharmacy		7,261		45			15
16	Medical Records & Library		5,430		16			16
17	Social Service		1,784		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	PARAMDICAL ED PROGRAM XRAY		647		13			23
23.01	PASTORAL EDUCATION PROGRAM		475		9			23.01
23.02	PARAMED EDUC EMT PROGRAM		5,549		8	8,035		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	115,985	113,290	75,443	337	348,185		30
31	Intensive Care Unit	10,553	9,631	8,334	58	60,465		31
34.01	NEONATAL INTENSIVE CARE	10,014	12,867		71	73,269		34.01
34.02	PEDIATRIC INTENSIVE CARE		3,520	2,379	15	15,030		34.02
40	Subprovider - IPF	2,817	10,731	6,856	26			40
43	Nursery	1,714	7,822		38			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	54,645	39,801		97	99,910		50
51	Recovery Room	2,581	3,103		11	11,811		51
52	Delivery Room & Labor Room	17,083	13,533		36	37,122		52
53	Anesthesiology		893		6	5,734		53
54	Radiology-Diagnostic	11,800	11,298		42			54
55	Radiology-Therapeutic	1,438	12,933		15			55
56	Radioisotope	10	1,409		3			56
60	Laboratory	3,070	15,994		115			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		720		3			63
65	Respiratory Therapy	52	10,661		38			65
66	Physical Therapy	145	5,322		7			66
69	Electrocardiology		8,228		17	18,018		69
70	Electroencephalography		512		9	9,823		70
71	Medical Supplies Charged to Patients						5,106,418	71
72	Impl. Dev. Charged to Patients						7,410,422	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		1,699					74
76	GI LAB	4,698	7,907		7	7,369		76
76.01	MRI	2,808	5,650		7			76.01
76.02	CT SCAN		2,861		10			76.02
76.03	CARDIAC CATHETERIZATIN	3,766	5,387		13	12,997		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	3,164	3,421		3	3,215		76.08
76.10	GENETIC SERVICES	57	5,682		9			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		5,553		10	9,900		90.01
90.02	ANTENATAL TEST CENTER	2,733	5,225		5	4,950		90.02
90.03	CHILD PSYCHIATRIC CLINIC	88	1,646		3	3,585		90.03
91	Emergency	65,862	16,442	1,635	87	90,162		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		5,856		1	956		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)	316,861	424,277	94,647	1,262	820,536	12,516,840	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		523					192
193.0	BELOIT HEART STANDBY							193.0
1								1
194	GUEST CENTER	1,419	5,118		2			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		3			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)	804,986	2,439,677	1,430,683	1,792,723	3,137,527	2,741,292	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,529,176	5,535,800	15,115,989	1,412,705,280	3,823,753	0,219,008	203
204	Cost to be allocated (Per Wkst. B, Part II)	30,887	89,475	86,327	85,252	109,257	283,604	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0,097,043	0,203,025	0,912,094	67,180,457	0,133,153	0,022,658	205

KPMG LLP Compu-Max 2552-10

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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	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	6,778,872					15
16	Medical Records & Library		492,965,958				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	PARAMEDICAL ED PROGRAM XRAY				100		23
23.01	PASTORAL EDUCATION PROGRAM					32,516	23.01
23.02	PARAMED EDUC EMT PROGRAM						640
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		29,896,199	6,661		20,522	17
31	Intensive Care Unit		7,169,111			2,267	31
34.01	NEONATAL INTENSIVE CARE		18,052,471	102		5,935	34
34.02	PEDIATRIC INTENSIVE CARE		2,531,294	29		647	34.02
40	Subprovider - IPF		2,355,110	972		1,865	40
43	Nursery		7,687,551	57		1,280	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		33,042,037				89
51	Recovery Room		4,023,335				51
52	Delivery Room & Labor Room		8,324,909				17
53	Anesthesiology	140,213	6,104,168				53
54	Radiology-Diagnostic		21,834,991		100		54
55	Radiology-Therapeutic		5,723,219				55
56	Radioisotope		4,554,916				56
60	Laboratory		33,542,559				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		5,476,700				63
65	Respiratory Therapy		14,461,812				13
66	Physical Therapy		3,500,203				66
69	Electrocardiology		16,090,363				69
70	Electroencephalography		4,633,026				70
71	Medical Supplies Charged to Patients		73,804,786				71
72	Impl. Dev. Charged to Patients		42,634,302				72
73	Drugs Charged to Patients	6,638,659	57,440,904				73
74	Renal Dialysis		672,310				74
76	GI LAB		3,609,672				76
76.01	MRI		12,358,000				76.01
76.02	CT SCAN		24,006,875				76.02
76.03	CARDIAC CATHETERIZATIN		11,433,087				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		1,149,403				76.08
76.10	GENETIC SERVICES		468,779				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		4,225,390				90.01
90.02	ANTENATAL TEST CENTER		4,082,402				90.02
90.03	CHILD PSYCHIATRIC CLINIC		159,442				90.03
91	Emergency		27,664,313				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	ASSIGNED TIME	PARA MED EDUC EMT TIME SPENT	
		15	16	17	23	23.01	23.02	
95	Ambulance Services		236,695					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)	6,778,872	492,950,334	7,821	100	32,516	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		15,624					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)	4,094,493	1,717,580	293,409	144,832	73,206	720,023	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.604008	0.003484	37.515535	1,448.320000	2.251384	1,125.035938	203
204	Cost to be allocated (Per Wkst. B, Part II)	248,001	63,837	10,633	5,260	2,953	28,530	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.036584	0.000129	1.359545	52.600000	0.090817	44.578125	205

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET		
DESCRIPTION		PART	LINE NO.	AMOUNT
1		2	3	4

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	26,008,008		26,008,008	129,968	26,137,976	30
31	Intensive Care Unit	5,585,976		5,585,976		5,585,976	31
34.01	NEONATAL INTENSIVE CARE	5,800,653		5,800,653	19,548	5,820,201	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,218,794		1,218,794		1,218,794	34.02
40	Subprovider - IPF	2,112,841		2,112,841	27,001	2,139,842	40
43	Nursery	2,554,124		2,554,124		2,554,124	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,857,239		12,857,239		12,857,239	50
51	Recovery Room	1,140,489		1,140,489		1,140,489	51
52	Delivery Room & Labor Room	3,231,092		3,231,092	477,230	3,708,322	52
53	Anesthesiology	1,400,863		1,400,863	21,683	1,422,546	53
54	Radiology-Diagnostic	3,821,031		3,821,031		3,821,031	54
55	Radiology-Therapeutic	1,975,434		1,975,434		1,975,434	55
56	Radioisotope	662,141		662,141		662,141	56
60	Laboratory	7,984,643		7,984,643		7,984,643	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	918,467		918,467		918,467	63
65	Respiratory Therapy	3,009,838		3,009,838		3,009,838	65
66	Physical Therapy	1,393,241		1,393,241		1,393,241	66
69	Electrocardiology	1,641,712		1,641,712		1,641,712	69
70	Electroencephalography	778,437		778,437		778,437	70
71	Medical Supplies Charged to Patients	8,165,258		8,165,258		8,165,258	71
72	Impl. Dev. Charged to Patients	11,544,199		11,544,199		11,544,199	72
73	Drugs Charged to Patients	12,148,146		12,148,146		12,148,146	73
74	Renal Dialysis	472,298		472,298		472,298	74
76	GI LAB	1,004,606		1,004,606		1,004,606	76
76.01	MRI	1,089,966		1,089,966		1,089,966	76.01
76.02	CT SCAN	1,010,778		1,010,778		1,010,778	76.02
76.03	CARDIAC CATHETERIZATIN	1,408,064		1,408,064		1,408,064	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	415,608		415,608		415,608	76.08
76.10	GENETIC SERVICES	939,701		939,701		939,701	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	774,305		774,305		774,305	90.01
90.02	ANTENATAL TEST CENTER	703,778		703,778		703,778	90.02
90.03	CHILD PSYCHIATRIC CLINIC	361,873		361,873		361,873	90.03
91	Emergency	7,615,904		7,615,904	33,446	7,649,350	91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	422,669		422,669		422,669	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)	132,172,176		132,172,176	708,876	132,881,052	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	132,172,176		132,172,176		132,881,052	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	20,579,528		20,579,528				30
31	Intensive Care Unit	7,137,283		7,137,283				31
34.01	NEONATAL INTENSIVE CARE	18,052,398		18,052,398				34.01
34.02	PEDIATRIC INTENSIVE CARE	2,497,133		2,497,133				34.02
40	Subprovider - IPF	2,355,110		2,355,110				40
43	Nursery	7,687,551		7,687,551				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,252,008	15,790,030	33,042,038	0.389118	0.389118	0.389118	50
51	Recovery Room	2,120,023	1,903,311	4,023,334	0.283469	0.283469	0.283469	51
52	Delivery Room & Labor Room	6,954,689	1,370,220	8,324,909	0.388123	0.388123	0.445449	52
53	Anesthesiology	3,200,303	2,903,865	6,104,168	0.229493	0.229493	0.233045	53
54	Radiology-Diagnostic	10,648,801	11,186,190	21,834,991	0.174996	0.174996	0.174996	54
55	Radiology-Therapeutic	158,997	5,564,222	5,723,219	0.345161	0.345161	0.345161	55
56	Radioisotope	888,818	3,666,098	4,554,916	0.145368	0.145368	0.145368	56
60	Laboratory	21,277,361	12,265,198	33,542,559	0.238045	0.238045	0.238045	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	4,397,137	1,079,563	5,476,700	0.167704	0.167704	0.167704	63
65	Respiratory Therapy	13,445,538	1,016,275	14,461,813	0.208123	0.208123	0.208123	65
66	Physical Therapy	2,616,420	883,783	3,500,203	0.398046	0.398046	0.398046	66
69	Electrocardiology	5,576,639	10,513,724	16,090,363	0.102031	0.102031	0.102031	69
70	Electroencephalography	759,998	3,873,029	4,633,027	0.168019	0.168019	0.168019	70
71	Medical Supplies Charged to Patients	51,389,908	22,414,877	73,804,785	0.110633	0.110633	0.110633	71
72	Impl. Dev. Charged to Patients	29,868,025	12,766,277	42,634,302	0.270773	0.270773	0.270773	72
73	Drugs Charged to Patients	30,522,135	26,918,768	57,440,903	0.211489	0.211489	0.211489	73
74	Renal Dialysis	597,077	75,233	672,310	0.702500	0.702500	0.702500	74
76	GI LAB	1,194,408	2,415,264	3,609,672	0.278309	0.278309	0.278309	76
76.01	MRI	2,874,262	9,483,738	12,358,000	0.088199	0.088199	0.088199	76.01
76.02	CT SCAN	9,376,882	14,629,994	24,006,876	0.042104	0.042104	0.042104	76.02
76.03	CARDIAC CATHETERIZATIN	5,515,581	5,917,507	11,433,088	0.123157	0.123157	0.123157	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	9,611	1,139,792	1,149,403	0.361586	0.361586	0.361586	76.08
76.10	GENETIC SERVICES	84,102	384,677	468,779	2.004571	2.004571	2.004571	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	31,866	4,193,525	4,225,391	0.183250	0.183250	0.183250	90.01
90.02	ANTENATAL TEST CENTER	156,071	3,926,331	4,082,402	0.172393	0.172393	0.172393	90.02
90.03	CHILD PSYCHIATRIC CLINIC	240	159,201	159,441	2.269636	2.269636	2.269636	90.03
91	Emergency	8,313,188	19,351,125	27,664,313	0.275297	0.275297	0.276506	91
92	Observation Beds (Non-Distinct Part)		9,385,718	9,385,718				92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	219,661	17,034	236,695	1.785712	1.785712	1.785712	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)	287,758,752	205,194,569	492,953,321				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	287,758,752	205,194,569	492,953,321				202

KPMG LLP Compu-Max 2552-10

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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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,676,557		1,676,557	20,522	81.70	8,901	727,212	30
31	Intensive Care Unit	297,964		297,964	2,267	131.44	1,008	132,492	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	295,545		295,545	5,935	49.80			34.01
34.02	PEDIATRIC INTENSIVE CARE	48,751		48,751	647	75.35			34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	105,771		105,771	1,865	56.71	503	28,525	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	80,018		80,018	1,280	62.51			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,504,606		2,504,606	32,516		10,412	888,229	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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) [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	1,174,349	33,042,038	0.035541	7,072,721	251,372	50
51	Recovery Room	39,750	4,023,334	0.009880	815,597	8,058	51
52	Delivery Room & Labor Room	242,625	8,324,909	0.029144	14,472	422	52
53	Anesthesiology	133,999	6,104,168	0.021952	987,285	21,673	53
54	Radiology-Diagnostic	486,490	21,834,991	0.022280	3,688,381	82,177	54
55	Radiology-Therapeutic	353,005	5,723,219	0.061679	50,949	3,142	55
56	Radioisotope	21,245	4,554,916	0.004664	473,874	2,210	56
60	Laboratory	555,904	33,542,559	0.016573	8,243,488	136,619	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	34,753	5,476,700	0.006346	1,202,518	7,631	63
65	Respiratory Therapy	178,907	14,461,813	0.012371	3,384,337	41,868	65
66	Physical Therapy	48,019	3,500,203	0.013719	1,252,058	17,177	66
69	Electrocardiology	178,229	16,090,363	0.011077	2,425,089	26,863	69
70	Electroencephalography	77,581	4,633,027	0.016745	200,727	3,361	70
71	Medical Supplies Charged to Pat	297,179	73,804,785	0.004027	18,052,894	72,699	71
72	Impl. Dev. Charged to Patients	420,563	42,634,302	0.009864	9,866,621	97,324	72
73	Drugs Charged to Patients	451,045	57,440,903	0.007852	10,681,594	83,872	73
74	Renal Dialysis	18,805	672,310	0.027971	493,598	13,806	74
76	GI LAB	232,774	3,609,672	0.064486	504,958	32,563	76
76.01	MRI	251,617	12,358,000	0.020361	1,102,642	22,451	76.01
76.02	CT SCAN	132,844	24,006,876	0.005534	3,621,807	20,043	76.02
76.03	CARDIAC CATHETERIZATIN	181,584	11,433,088	0.015882	1,721,177	27,336	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	27,765	1,149,403	0.024156			76.08
76.10	GENETIC SERVICES	66,584	468,779	0.142037			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	98,121	4,225,391	0.023222	1,733	40	90.01
90.02	ANTENATAL TEST CENTER	53,405	4,082,402	0.013082			90.02
90.03	CHILD PSYCHIATRIC CLINIC	12,431	159,441	0.077966			90.03
91	Emergency	508,319	27,664,313	0.018375	3,410,888	62,675	91
92	Observation Beds (Non-Distinct		9,385,718				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	6,277,892	434,407,623		79,269,408	1,035,382	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)		65,328			65,328	30
31	Intensive Care Unit		5,104			5,104	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
34.01	NEONATAL INTENSIVE CARE		51,613			51,613	34.01
34.02	PEDIATRIC INTENSIVE CARE		1,457			1,457	34.02
35	Other Special Care (specify)						35
40	Subprovider - IPF		4,199			4,199	40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery		2,882			2,882	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		130,583			130,583	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	20,522	3.18	8,901	28,305	30
31	Intensive Care Unit	2,267	2.25	1,008	2,268	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	5,935	8.70			34.01
34.02	PEDIATRIC INTENSIVE CARE	647	2.25			34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	1,865	2.25	503	1,132	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,280	2.25			43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	32,516		10,412	31,705	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [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			100,128		100,128	100,128	50
51	Recovery Room							51
52	Delivery Room & Labor Room			19,126		19,126	19,126	52
53	Anesthesiology							53
54	Radiology-Diagnostic			144,832		144,832	144,832	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy			14,625		14,625	14,625	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							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 CATHETERIZATIN							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			528,767		528,767	528,767	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			807,478		807,478	807,478	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [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	33,042,038	0.003030	0.003030	7,072,721	21,430	5,218,227	15,811	50
51	Recovery Room	4,023,334			815,597		482,802		51
52	Delivery Room & Labor Room	8,324,909	0.002297	0.002297	14,472	33	6,842	16	52
53	Anesthesiology	6,104,168			987,285		757,529		53
54	Radiology-Diagnostic	21,834,991	0.006633	0.006633	3,688,381	24,465	3,142,402	20,844	54
55	Radiology-Therapeutic	5,723,219			50,949		882,653		55
56	Radioisotope	4,554,916			473,874		1,151,009		56
60	Laboratory	33,542,559			8,243,488		2,155,107		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	5,476,700			1,202,518		178,011		63
65	Respiratory Therapy	14,461,813	0.001011	0.001011	3,384,337	3,422	190,195	192	65
66	Physical Therapy	3,500,203			1,252,058		1,649		66
69	Electrocardiology	16,090,363			2,425,089		2,288,466		69
70	Electroencephalography	4,633,027			200,727		672,155		70
71	Medical Supplies Charged to Pat	73,804,785			18,052,894		6,482,356		71
72	Impl. Dev. Charged to Patients	42,634,302			9,866,621		4,199,211		72
73	Drugs Charged to Patients	57,440,903			10,681,594		7,494,056		73
74	Renal Dialysis	672,310			493,598		9,526		74
76	GI LAB	3,609,672			504,958		418,282		76
76.01	MRI	12,358,000			1,102,642		2,023,094		76.01
76.02	CT SCAN	24,006,876			3,621,807		3,660,155		76.02
76.03	CARDIAC CATHETERIZATIN	11,433,088			1,721,177		2,178,781		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	1,149,403							76.08
76.10	GENETIC SERVICES	468,779							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	4,225,391			1,733		70,601		90.01
90.02	ANTENATAL TEST CENTER	4,082,402							90.02
90.03	CHILD PSYCHIATRIC CLINIC	159,441							90.03
91	Emergency	27,664,313	0.019114	0.019114	3,410,888	65,196	4,496,959	85,955	91
92	Observation Beds (Non-Distinct	9,385,718					1,039,739		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	434,407,623			79,269,408	114,546	49,199,807	122,818	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID

(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	0.389118	5,218,227			2,030,506		50	
51	Recovery Room	0.283469	482,802			136,859		51	
52	Delivery Room & Labor Room	0.388123	6,842			2,656		52	
53	Anesthesiology	0.229493	757,529			173,848		53	
54	Radiology-Diagnostic	0.174996	3,142,402			549,908		54	
55	Radiology-Therapeutic	0.345161	882,653			304,657		55	
56	Radioisotope	0.145368	1,151,009			167,320		56	
60	Laboratory	0.238045	2,155,107			513,012		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.167704	178,011			29,853		63	
65	Respiratory Therapy	0.208123	190,195			39,584		65	
66	Physical Therapy	0.398046	1,649			656		66	
69	Electrocardiology	0.102031	2,288,466			233,494		69	
70	Electroencephalography	0.168019	672,155			112,935		70	
71	Medical Supplies Charged to Pat	0.110633	6,482,356			717,162		71	
72	Impl. Dev. Charged to Patients	0.270773	4,199,211			1,137,033		72	
73	Drugs Charged to Patients	0.211489	7,494,056		54,653	1,584,910		11,559	
74	Renal Dialysis	0.702500	9,526			6,692		74	
76	GI LAB	0.278309	418,282			116,412		76	
76.01	MRI	0.088199	2,023,094			178,435		76.01	
76.02	CT SCAN	0.042104	3,660,155			154,107		76.02	
76.03	CARDIAC CATHETERIZATIN	0.123157	2,178,781			268,332		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	0.361586						76.08	
76.10	GENETIC SERVICES	2.004571						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	0.183250	70,601			12,938		90.01	
90.02	ANTENATAL TEST CENTER	0.172393						90.02	
90.03	CHILD PSYCHIATRIC CLINIC	2.269636						90.03	
91	Emergency	0.275297	4,496,959			1,237,999		91	
92	Observation Beds (Non-Distinct		1,039,739					92	
OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services	1.785712						95	
200	Subtotal (see instructions)		49,199,807		54,653	9,709,308		11,559	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		49,199,807		54,653	9,709,308		11,559	

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	1,174,349	33,042,038	0.035541			50
51	Recovery Room	39,750	4,023,334	0.009880			51
52	Delivery Room & Labor Room	242,625	8,324,909	0.029144			52
53	Anesthesiology	133,999	6,104,168	0.021952			53
54	Radiology-Diagnostic	486,490	21,834,991	0.022280	6,767	151	54
55	Radiology-Therapeutic	353,005	5,723,219	0.061679			55
56	Radioisotope	21,245	4,554,916	0.004664			56
60	Laboratory	555,904	33,542,559	0.016573	97,277	1,612	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	34,753	5,476,700	0.006346			63
65	Respiratory Therapy	178,907	14,461,813	0.012371	1,406	17	65
66	Physical Therapy	48,019	3,500,203	0.013719	3,697	51	66
69	Electrocardiology	178,229	16,090,363	0.011077	1,986	22	69
70	Electroencephalography	77,581	4,633,027	0.016745			70
71	Medical Supplies Charged to Pat	297,179	73,804,785	0.004027	1,297	5	71
72	Impl. Dev. Charged to Patients	420,563	42,634,302	0.009864			72
73	Drugs Charged to Patients	451,045	57,440,903	0.007852	95,434	749	73
74	Renal Dialysis	18,805	672,310	0.027971			74
76	GI LAB	232,774	3,609,672	0.064486			76
76.01	MRI	251,617	12,358,000	0.020361	3,116	63	76.01
76.02	CT SCAN	132,844	24,006,876	0.005534	7,352	41	76.02
76.03	CARDIAC CATHETERIZATIN	181,584	11,433,088	0.015882			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	27,765	1,149,403	0.024156			76.08
76.10	GENETIC SERVICES	66,584	468,779	0.142037			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	98,121	4,225,391	0.023222			90.01
90.02	ANTENATAL TEST CENTER	53,405	4,082,402	0.013082			90.02
90.03	CHILD PSYCHIATRIC CLINIC	12,431	159,441	0.077966			90.03
91	Emergency	508,319	27,664,313	0.018375	66,211	1,217	91
92	Observation Beds (Non-Distinct		9,385,718				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	6,277,892	434,407,623		284,543	3,928	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			100,128		100,128	100,128	50
51	Recovery Room							51
52	Delivery Room & Labor Room			19,126		19,126	19,126	52
53	Anesthesiology							53
54	Radiology-Diagnostic			144,832		144,832	144,832	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy			14,625		14,625	14,625	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							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 CATHETERIZATIN							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			528,767		528,767	528,767	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			807,478		807,478	807,478	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [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	33,042,038	0.003030	0.003030					50
51	Recovery Room	4,023,334							51
52	Delivery Room & Labor Room	8,324,909	0.002297	0.002297					52
53	Anesthesiology	6,104,168							53
54	Radiology-Diagnostic	21,834,991	0.006633	0.006633	6,767	45			54
55	Radiology-Therapeutic	5,723,219							55
56	Radioisotope	4,554,916							56
60	Laboratory	33,542,559			97,277				60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	5,476,700							63
65	Respiratory Therapy	14,461,813	0.001011	0.001011	1,406	1			65
66	Physical Therapy	3,500,203			3,697				66
69	Electrocardiology	16,090,363			1,986				69
70	Electroencephalography	4,633,027							70
71	Medical Supplies Charged to Pat	73,804,785			1,297				71
72	Impl. Dev. Charged to Patients	42,634,302							72
73	Drugs Charged to Patients	57,440,903			95,434				73
74	Renal Dialysis	672,310							74
76	GI LAB	3,609,672							76
76.01	MRI	12,358,000			3,116				76.01
76.02	CT SCAN	24,006,876			7,352				76.02
76.03	CARDIAC CATHETERIZATIN	11,433,088							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	1,149,403							76.08
76.10	GENETIC SERVICES	468,779							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	4,225,391							90.01
90.02	ANTENATAL TEST CENTER	4,082,402							90.02
90.03	CHILD PSYCHIATRIC CLINIC	159,441							90.03
91	Emergency	27,664,313	0.019114	0.019114	66,211	1,266			91
92	Observation Beds (Non-Distinct	9,385,718							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	434,407,623			284,543	1,312			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID

(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.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.389118						50
51	Recovery Room	0.283469						51
52	Delivery Room & Labor Room	0.388123						52
53	Anesthesiology	0.229493						53
54	Radiology-Diagnostic	0.174996						54
55	Radiology-Therapeutic	0.345161						55
56	Radioisotope	0.145368						56
60	Laboratory	0.238045						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.167704						63
65	Respiratory Therapy	0.208123						65
66	Physical Therapy	0.398046						66
69	Electrocardiology	0.102031						69
70	Electroencephalography	0.168019						70
71	Medical Supplies Charged to Pat	0.110633						71
72	Impl. Dev. Charged to Patients	0.270773						72
73	Drugs Charged to Patients	0.211489						73
74	Renal Dialysis	0.702500						74
76	GI LAB	0.278309						76
76.01	MRI	0.088199						76.01
76.02	CT SCAN	0.042104						76.02
76.03	CARDIAC CATHETERIZATIN	0.123157						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	0.361586						76.08
76.10	GENETIC SERVICES	2.004571						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	0.183250						90.01
90.02	ANTENATAL TEST CENTER	0.172393						90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636						90.03
91	Emergency	0.275297						91
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1.785712						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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	1,676,557		1,676,557	20,522	81.70	5,065	413,811	30
31	Intensive Care Unit	297,964		297,964	2,267	131.44	1,078	141,692	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	295,545		295,545	5,935	49.80	2,302	114,640	34.01
34.02	PEDIATRIC INTENSIVE CARE	48,751		48,751	647	75.35	393	29,613	34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	105,771		105,771	1,865	56.71	406	23,024	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	80,018		80,018	1,280	62.51	961	60,072	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,504,606		2,504,606	32,516		10,205	782,852	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	1,174,349	33,042,038	0.035541			50
51	Recovery Room	39,750	4,023,334	0.009880			51
52	Delivery Room & Labor Room	242,625	8,324,909	0.029144			52
53	Anesthesiology	133,999	6,104,168	0.021952			53
54	Radiology-Diagnostic	486,490	21,834,991	0.022280			54
55	Radiology-Therapeutic	353,005	5,723,219	0.061679			55
56	Radioisotope	21,245	4,554,916	0.004664			56
60	Laboratory	555,904	33,542,559	0.016573			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	34,753	5,476,700	0.006346			63
65	Respiratory Therapy	178,907	14,461,813	0.012371			65
66	Physical Therapy	48,019	3,500,203	0.013719			66
69	Electrocardiology	178,229	16,090,363	0.011077			69
70	Electroencephalography	77,581	4,633,027	0.016745			70
71	Medical Supplies Charged to Pat	297,179	73,804,785	0.004027			71
72	Impl. Dev. Charged to Patients	420,563	42,634,302	0.009864			72
73	Drugs Charged to Patients	451,045	57,440,903	0.007852			73
74	Renal Dialysis	18,805	672,310	0.027971			74
76	GI LAB	232,774	3,609,672	0.064486			76
76.01	MRI	251,617	12,358,000	0.020361			76.01
76.02	CT SCAN	132,844	24,006,876	0.005534			76.02
76.03	CARDIAC CATHETERIZATIN	181,584	11,433,088	0.015882			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	27,765	1,149,403	0.024156			76.08
76.10	GENETIC SERVICES	66,584	468,779	0.142037			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	98,121	4,225,391	0.023222			90.01
90.02	ANTENATAL TEST CENTER	53,405	4,082,402	0.013082			90.02
90.03	CHILD PSYCHIATRIC CLINIC	12,431	159,441	0.077966			90.03
91	Emergency	508,319	27,664,313	0.018375			91
92	Observation Beds (Non-Distinct		9,385,718				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	6,277,892	434,407,623				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)		65,328			65,328	30
31	Intensive Care Unit		5,104			5,104	31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
34.01	NEONATAL INTENSIVE CARE		51,613			51,613	34.01
34.02	PEDIATRIC INTENSIVE CARE		1,457			1,457	34.02
35	Other Special Care (specify)						35
40	Subprovider - IPF		4,199			4,199	40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery		2,882			2,882	43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)		130,583			130,583	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	20,522	3.18	5,065	16,107	30
31	Intensive Care Unit	2,267	2.25	1,078	2,426	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	5,935	8.70	2,302	20,027	34.01
34.02	PEDIATRIC INTENSIVE CARE	647	2.25	393	884	34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	1,865	2.25	406	914	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,280	2.25	961	2,162	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	32,516		10,205	42,520	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] PPS
 Applicable [] Title XVIII, Part A [] 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			100,128		100,128	100,128	50
51	Recovery Room							51
52	Delivery Room & Labor Room			19,126		19,126	19,126	52
53	Anesthesiology							53
54	Radiology-Diagnostic			144,832		144,832	144,832	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy			14,625		14,625	14,625	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							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 CATHETERIZATIN							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			528,767		528,767	528,767	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			807,478		807,478	807,478	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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	33,042,038	0.003030	0.003030					50
51	Recovery Room	4,023,334							51
52	Delivery Room & Labor Room	8,324,909	0.002297	0.002297					52
53	Anesthesiology	6,104,168							53
54	Radiology-Diagnostic	21,834,991	0.006633	0.006633					54
55	Radiology-Therapeutic	5,723,219							55
56	Radioisotope	4,554,916							56
60	Laboratory	33,542,559							60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	5,476,700							63
65	Respiratory Therapy	14,461,813	0.001011	0.001011					65
66	Physical Therapy	3,500,203							66
69	Electrocardiology	16,090,363							69
70	Electroencephalography	4,633,027							70
71	Medical Supplies Charged to Pat	73,804,785							71
72	Impl. Dev. Charged to Patients	42,634,302							72
73	Drugs Charged to Patients	57,440,903							73
74	Renal Dialysis	672,310							74
76	GI LAB	3,609,672							76
76.01	MRI	12,358,000							76.01
76.02	CT SCAN	24,006,876							76.02
76.03	CARDIAC CATHETERIZATIN	11,433,088							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	1,149,403							76.08
76.10	GENETIC SERVICES	468,779							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	4,225,391							90.01
90.02	ANTENATAL TEST CENTER	4,082,402							90.02
90.03	CHILD PSYCHIATRIC CLINIC	159,441							90.03
91	Emergency	27,664,313	0.019114	0.019114					91
92	Observation Beds (Non-Distinct	9,385,718							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	434,407,623							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID

(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.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.389118						50
51	Recovery Room	0.283469						51
52	Delivery Room & Labor Room	0.388123						52
53	Anesthesiology	0.229493						53
54	Radiology-Diagnostic	0.174996						54
55	Radiology-Therapeutic	0.345161						55
56	Radioisotope	0.145368						56
60	Laboratory	0.238045						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.167704						63
65	Respiratory Therapy	0.208123						65
66	Physical Therapy	0.398046						66
69	Electrocardiology	0.102031						69
70	Electroencephalography	0.168019						70
71	Medical Supplies Charged to Pat	0.110633						71
72	Impl. Dev. Charged to Patients	0.270773						72
73	Drugs Charged to Patients	0.211489						73
74	Renal Dialysis	0.702500						74
76	GI LAB	0.278309						76
76.01	MRI	0.088199						76.01
76.02	CT SCAN	0.042104						76.02
76.03	CARDIAC CATHETERIZATIN	0.123157						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	0.361586						76.08
76.10	GENETIC SERVICES	2.004571						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	0.183250						90.01
90.02	ANTENATAL TEST CENTER	0.172393						90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636						90.03
91	Emergency	0.275297						91
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1.785712						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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	1,174,349	33,042,038	0.035541			50
51	Recovery Room	39,750	4,023,334	0.009880			51
52	Delivery Room & Labor Room	242,625	8,324,909	0.029144			52
53	Anesthesiology	133,999	6,104,168	0.021952			53
54	Radiology-Diagnostic	486,490	21,834,991	0.022280			54
55	Radiology-Therapeutic	353,005	5,723,219	0.061679			55
56	Radioisotope	21,245	4,554,916	0.004664			56
60	Laboratory	555,904	33,542,559	0.016573			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	34,753	5,476,700	0.006346			63
65	Respiratory Therapy	178,907	14,461,813	0.012371			65
66	Physical Therapy	48,019	3,500,203	0.013719			66
69	Electrocardiology	178,229	16,090,363	0.011077			69
70	Electroencephalography	77,581	4,633,027	0.016745			70
71	Medical Supplies Charged to Pat	297,179	73,804,785	0.004027			71
72	Impl. Dev. Charged to Patients	420,563	42,634,302	0.009864			72
73	Drugs Charged to Patients	451,045	57,440,903	0.007852			73
74	Renal Dialysis	18,805	672,310	0.027971			74
76	GI LAB	232,774	3,609,672	0.064486			76
76.01	MRI	251,617	12,358,000	0.020361			76.01
76.02	CT SCAN	132,844	24,006,876	0.005534			76.02
76.03	CARDIAC CATHETERIZATIN	181,584	11,433,088	0.015882			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	27,765	1,149,403	0.024156			76.08
76.10	GENETIC SERVICES	66,584	468,779	0.142037			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	98,121	4,225,391	0.023222			90.01
90.02	ANTENATAL TEST CENTER	53,405	4,082,402	0.013082			90.02
90.03	CHILD PSYCHIATRIC CLINIC	12,431	159,441	0.077966			90.03
91	Emergency	508,319	27,664,313	0.018375			91
92	Observation Beds (Non-Distinct		9,385,718				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	6,277,892	434,407,623				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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			100,128		100,128	100,128	50
51	Recovery Room							51
52	Delivery Room & Labor Room			19,126		19,126	19,126	52
53	Anesthesiology							53
54	Radiology-Diagnostic			144,832		144,832	144,832	54
55	Radiology-Therapeutic							55
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
65	Respiratory Therapy			14,625		14,625	14,625	65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							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 CATHETERIZATIN							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			528,767		528,767	528,767	91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)			807,478		807,478	807,478	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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	33,042,038	0.003030	0.003030					50
51	Recovery Room	4,023,334							51
52	Delivery Room & Labor Room	8,324,909	0.002297	0.002297					52
53	Anesthesiology	6,104,168							53
54	Radiology-Diagnostic	21,834,991	0.006633	0.006633					54
55	Radiology-Therapeutic	5,723,219							55
56	Radioisotope	4,554,916							56
60	Laboratory	33,542,559							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	5,476,700							63
65	Respiratory Therapy	14,461,813	0.001011	0.001011					65
66	Physical Therapy	3,500,203							66
69	Electrocardiology	16,090,363							69
70	Electroencephalography	4,633,027							70
71	Medical Supplies Charged to Pat	73,804,785							71
72	Impl. Dev. Charged to Patients	42,634,302							72
73	Drugs Charged to Patients	57,440,903							73
74	Renal Dialysis	672,310							74
76	GI LAB	3,609,672							76
76.01	MRI	12,358,000							76.01
76.02	CT SCAN	24,006,876							76.02
76.03	CARDIAC CATHETERIZATIN	11,433,088							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	1,149,403							76.08
76.10	GENETIC SERVICES	468,779							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	4,225,391							90.01
90.02	ANTENATAL TEST CENTER	4,082,402							90.02
90.03	CHILD PSYCHIATRIC CLINIC	159,441							90.03
91	Emergency	27,664,313	0.019114	0.019114					91
92	Observation Beds (Non-Distinct	9,385,718							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	434,407,623							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID

(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.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.389118						50
51	Recovery Room	0.283469						51
52	Delivery Room & Labor Room	0.388123						52
53	Anesthesiology	0.229493						53
54	Radiology-Diagnostic	0.174996						54
55	Radiology-Therapeutic	0.345161						55
56	Radioisotope	0.145368						56
60	Laboratory	0.238045						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.167704						63
65	Respiratory Therapy	0.208123						65
66	Physical Therapy	0.398046						66
69	Electrocardiology	0.102031						69
70	Electroencephalography	0.168019						70
71	Medical Supplies Charged to Pat	0.110633						71
72	Impl. Dev. Charged to Patients	0.270773						72
73	Drugs Charged to Patients	0.211489						73
74	Renal Dialysis	0.702500						74
76	GI LAB	0.278309						76
76.01	MRI	0.088199						76.01
76.02	CT SCAN	0.042104						76.02
76.03	CARDIAC CATHETERIZATIN	0.123157						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	0.361586						76.08
76.10	GENETIC SERVICES	2.004571						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	0.183250						90.01
90.02	ANTENATAL TEST CENTER	0.172393						90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636						90.03
91	Emergency	0.275297						91
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1.785712						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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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)	20,522	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,522	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)	20,522	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)	8,901	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)	26,137,976	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)	26,137,976	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)	26,137,976	37

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)						1,273.66	38
39	Program general inpatient routine service cost (line 9 x line 38)						11,336,848	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)						11,336,848	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	5,585,976	2,267	2,464.04	1,008	2,483,752		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
46.01	NEONATAL INTENSIVE CARE	5,820,201	5,935	980.66				46.01
46.02	PEDIATRIC INTENSIVE CARE	1,218,794	647	1,883.76				46.02
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						16,420,012	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						30,240,612	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						890,277	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						1,149,928	51
52	Total Program excludable cost (sum of lines 50 and 51)						2,040,205	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						28,200,407	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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID 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)							87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,273.66	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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] 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)	1,865	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,865	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)	1,865	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)	503	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)	2,139,842	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)	2,139,842	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)	2,139,842	37

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,147.37	38
39	Program general inpatient routine service cost (line 9 x line 38)	577,127	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)	577,127	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	65,527	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	642,654	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	29,657	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,240	51
52	Total Program excludable cost (sum of lines 50 and 51)	34,897	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	607,757	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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [] PPS
 Applicable [] Title XVIII, Part A [] 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)	20,522	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,522	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)	20,522	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)	5,065	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)	1,280	15
16	Nursery days (title V or XIX only)	961	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)	26,008,008	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)	26,008,008	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)	26,008,008	37

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,267.32	38
39	Program general inpatient routine service cost (line 9 x line 38)						6,418,976	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)						6,418,976	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)	2,554,124	1,280	1,995.41	961	1,917,589		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,585,976	2,267	2,464.04	1,078	2,656,235		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
46.01	NEONATAL INTENSIVE CARE	5,800,653	5,935	977.36	2,302	2,249,883		46.01
46.02	PEDIATRIC INTENSIVE CARE	1,218,794	647	1,883.76	393	740,318		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)						13,983,001	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					801,434		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)					801,434		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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID 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)						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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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)	1,865	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,865	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)	1,865	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)	406	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)	2,112,841	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)	2,112,841	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)	2,112,841	37

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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 [XX] 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

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,132.89	38
39	Program general inpatient routine service cost (line 9 x line 38)	459,953	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)	459,953	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)	459,953	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	23,938	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)	23,938	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthesiologist 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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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		9,177,335		30
31	Intensive Care Unit		3,037,536		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	0.389118	7,072,721	2,752,123	50
51	Recovery Room	0.283469	815,597	231,196	51
52	Delivery Room & Labor Room	0.445449	14,472	6,447	52
53	Anesthesiology	0.233045	987,285	230,082	53
54	Radiology-Diagnostic	0.174996	3,688,381	645,452	54
55	Radiology-Therapeutic	0.345161	50,949	17,586	55
56	Radioisotope	0.145368	473,874	68,886	56
60	Laboratory	0.238045	8,243,488	1,962,321	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.167704	1,202,518	201,667	63
65	Respiratory Therapy	0.208123	3,384,337	704,358	65
66	Physical Therapy	0.398046	1,252,058	498,377	66
69	Electrocardiology	0.102031	2,425,089	247,434	69
70	Electroencephalography	0.168019	200,727	33,726	70
71	Medical Supplies Charged to Patients	0.110633	18,052,894	1,997,246	71
72	Impl. Dev. Charged to Patients	0.270773	9,866,621	2,671,615	72
73	Drugs Charged to Patients	0.211489	10,681,594	2,259,040	73
74	Renal Dialysis	0.702500	493,598	346,753	74
76	GI LAB	0.278309	504,958	140,534	76
76.01	MRI	0.088199	1,102,642	97,252	76.01
76.02	CT SCAN	0.042104	3,621,807	152,493	76.02
76.03	CARDIAC CATHETERIZATIN	0.123157	1,721,177	211,975	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	0.361586			76.08
76.10	GENETIC SERVICES	2.004571			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	0.183250	1,733	318	90.01
90.02	ANTENATAL TEST CENTER	0.172393			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636			90.03
91	Emergency	0.276506	3,410,888	943,131	91
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		79,269,408	16,420,012	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		79,269,408		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID [] 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		635,072		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.389118			50
51	Recovery Room	0.283469			51
52	Delivery Room & Labor Room	0.445449			52
53	Anesthesiology	0.233045			53
54	Radiology-Diagnostic	0.174996	6,767	1,184	54
55	Radiology-Therapeutic	0.345161			55
56	Radioisotope	0.145368			56
60	Laboratory	0.238045	97,277	23,156	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.167704			63
65	Respiratory Therapy	0.208123	1,406	293	65
66	Physical Therapy	0.398046	3,697	1,472	66
69	Electrocardiology	0.102031	1,986	203	69
70	Electroencephalography	0.168019			70
71	Medical Supplies Charged to Patients	0.110633	1,297	143	71
72	Impl. Dev. Charged to Patients	0.270773			72
73	Drugs Charged to Patients	0.211489	95,434	20,183	73
74	Renal Dialysis	0.702500			74
76	GI LAB	0.278309			76
76.01	MRI	0.088199	3,116	275	76.01
76.02	CT SCAN	0.042104	7,352	310	76.02
76.03	CARDIAC CATHETERIZATIN	0.123157			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	0.361586			76.10
76.11	CARDIOLOGY	2.004571			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	0.183250			90.01
90.02	ANTENATAL TEST CENTER	0.172393			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636			90.03
91	Emergency	0.276506	66,211	18,308	91
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		284,543	65,527	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		284,543		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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/IID 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	0.389118			50
51	Recovery Room	0.283469			51
52	Delivery Room & Labor Room	0.388123			52
53	Anesthesiology	0.229493			53
54	Radiology-Diagnostic	0.174996			54
55	Radiology-Therapeutic	0.345161			55
56	Radioisotope	0.145368			56
60	Laboratory	0.238045			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.167704			63
65	Respiratory Therapy	0.208123			65
66	Physical Therapy	0.398046			66
69	Electrocardiology	0.102031			69
70	Electroencephalography	0.168019			70
71	Medical Supplies Charged to Patients	0.110633			71
72	Impl. Dev. Charged to Patients	0.270773			72
73	Drugs Charged to Patients	0.211489			73
74	Renal Dialysis	0.702500			74
76	GI LAB	0.278309			76
76.01	MRI	0.088199			76.01
76.02	CT SCAN	0.042104			76.02
76.03	CARDIAC CATHETERIZATIN	0.123157			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	0.361586			76.08
76.10	GENETIC SERVICES	2.004571			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	0.183250			90.01
90.02	ANTENATAL TEST CENTER	0.172393			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636			90.03
91	Emergency	0.275297			91
92	Observation Beds (Non-Distinct Part)				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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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 IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID 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	0.389118			50
51	Recovery Room	0.283469			51
52	Delivery Room & Labor Room	0.388123			52
53	Anesthesiology	0.229493			53
54	Radiology-Diagnostic	0.174996			54
55	Radiology-Therapeutic	0.345161			55
56	Radioisotope	0.145368			56
60	Laboratory	0.238045			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.167704			63
65	Respiratory Therapy	0.208123			65
66	Physical Therapy	0.398046			66
69	Electrocardiology	0.102031			69
70	Electroencephalography	0.168019			70
71	Medical Supplies Charged to Patients	0.110633			71
72	Impl. Dev. Charged to Patients	0.270773			72
73	Drugs Charged to Patients	0.211489			73
74	Renal Dialysis	0.702500			74
76	GI LAB	0.278309			76
76.01	MRI	0.088199			76.01
76.02	CT SCAN	0.042104			76.02
76.03	CARDIAC CATHETERIZATIN	0.123157			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	0.361586			76.08
76.10	GENETIC SERVICES	2.004571			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	0.183250			90.01
90.02	ANTENATAL TEST CENTER	0.172393			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.269636			90.03
91	Emergency	0.275297			91
92	Observation Beds (Non-Distinct Part)				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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	18,624,019			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				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)	1,441,769			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	5,398,613			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	312.00			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)	0.0561			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3763			31
32	Sum of lines 30 and 31	0.4324			32
33	Allowable disproportionate share percentage (see instructions)	0.2488			33
34	Disproportionate share adjustment (see instructions)	1,158,414			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)	4,617,142			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,289,595			35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,289,595			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

KPMG LLP Compu-Max 2552-10

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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)	23,513,797			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)	23,513,797			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,754,829			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	160,671			53
54	Special add-on payments for new technologies				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).	30,573			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	114,546			58
59	Total (sum of amounts on lines 49 through 58)	25,574,416			59
60	Primary payer payments	14,932			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	25,559,484			61
62	Deductibles billed to program beneficiaries	1,921,000			62
63	Coinsurance billed to program beneficiaries	35,265			63
64	Allowable bad debts (see instructions)	530,315			64
65	Adjusted reimbursable bad debts (see instructions)	344,705			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	530,315			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,947,924			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)	-37,375			70.93
70.94	HRR adjustment amount (see instructions)	-83,808			70.94
71	Amount due provider (see instructions)	23,826,741			71
71.01	Sequestration adjustment (see instructions)	476,535			71.01
72	Interim payments	22,715,811			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	634,395			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	193,632			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)	0.000000000	0.000000000		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

KPMG LLP Compu-Max 2552-10

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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)	11,559			1
2	Medical and other services reimbursed under OPPS (see instructions)	9,586,490			2
3	PPS payments	8,374,836			3
4	Outlier payment (see instructions)	97,421			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	122,818			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	11,559			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	54,653			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)	54,653			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)	54,653			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	43,094			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)	11,559			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)	8,595,075			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,674,137			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)	6,932,497			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)	6,932,497			30
31	Primary payer payments	3,563			31
32	Subtotal (line 30 minus line 31)	6,928,934			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)	511,723			34
35	Adjusted reimbursable bad debts (see instructions)	332,620			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	511,723			36
37	Subtotal (see instructions)	7,261,554			37
38	MSP-LCC reconciliation amount from PS&R	189			38
39	Other adjustments (FORMULA DRIVEN OVERPAYMENT EST)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	7,261,365			40
40.01	Sequestration adjustment (see instructions)	145,227			40.01
41	Interim payments	6,943,712			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	172,426			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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S239

WORKSHEET E
PART B

Check applicable box: [] Hospital [XX] 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)				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

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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		22,715,811		6,943,712	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)		22,715,811		6,943,712	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)		634,395		172,426	6.01
7	Total Medicare program liability (see instructions)		23,350,206		7,116,138	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.

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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		320,167		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)		320,167		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	2,395		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		322,562		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.

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	6,405	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,909	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	2,807	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	29,371	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	492,953,321	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,268,812	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)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 06/30/2015	Run Date: 11/18/2015 Run Time: 00:47 Version: 2015.10 (11/09/2015)
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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)	405,319	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)	10,303867	9
10	Teaching adjustment factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$		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)	405,319	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)	405,319	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	405,319	18
19	Deductibles	54,048	19
20	Subtotal (line 18 minus line 19)	351,271	20
21	Coinsurance	24,570	21
22	Subtotal (line 20 minus line 21)	326,701	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	326,701	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)	2,444	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)	329,145	31
31.01	Sequestration adjustment (see instructions)	6,583	31.01
32	Interim payments	320,167	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	2,395	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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0239

WORKSHEET E-3
PART VII

Check [] Title V [XX] Hospital [] NF [] PPS
 Applicable [XX] Title XIX [] SUB (Other) [] ICF/IID [] 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	13,983,001	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	13,983,001	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	13,983,001	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)	13,983,001	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)	13,983,001	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

KPMG LLP Compu-Max 2552-10

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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/IID [] 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	459,953	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	459,953	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	459,953	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)	459,953	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)	459,953	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	45,416,757			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	47,265,549			4
5	Other receivables	5,853,690			5
6	Allowances for uncollectible notes and accounts receivable				6
7	Inventory	8,333,912			7
8	Prepaid expenses	1,521,110			8
9	Other current assets	13,160,000			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	121,551,018			11
FIXED ASSETS					
12	Land	2,600,972			12
13	Land improvements	7,340,745			13
14	Accumulated depreciation	-6,289,703			14
15	Buildings	54,804,308			15
16	Accumulated depreciation	-41,035,655			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	122,505,048			19
20	Accumulated depreciation	-84,155,406			20
21	Audomobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	129,459,557			23
24	Accumulated depreciation	-80,774,189			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)	104,455,677			30
OTHER ASSETS					
31	Investments	106,766,443			31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	22,708,616			34
35	Total other assets (sum of lines 31-34)	129,475,059			35
36	Total assets (sum of lines 11, 30 and 35)	355,481,754			36
Liabilities and Fund Balances (Omit Cents)					
		1	2	3	4
CURRENT LIABILITIES					
37	Accounts payable	6,984,141			37
38	Salaries, wages and fees payable	26,798,301			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)	3,992,028			40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	16,348,387			44
45	Total current liabilities (sum of lines 37 thru 44)	54,122,857			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable	58,670,861			47
48	Unsecured loans				48
49	Other long term liabilities	55,025,335			49
50	Total long term liabilities (sum of lines 46 thru 49)	113,696,196			50
51	Total liabilities (sum of lines 45 and 50)	167,819,053			51
CAPITAL ACCOUNTS					
52	General fund balance	187,662,701			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)	187,662,701			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	355,481,754			60

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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		180,824,803			1
2	Net income (loss) (from Worksheet G-3, line 29)		24,353,311			2
3	Total (sum of line 1 and line 2)		205,178,114			3
4	Additions (credit adjustments) (specify)					4
5	FAS 133 VALUATION CHANGE	3,850,581				5
6	RESTRICTED ASSETS CHANGE	66,076				6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		3,916,657			10
11	Subtotal (line 3 plus line 10)		209,094,771			11
12	Deductions (debit adjustments) (specify)					12
13	TRANFERS	21,432,070				13
14						14
15						15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)		21,432,070			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		187,662,701			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	FAS 133 VALUATION CHANGE					5
6	RESTRICTED ASSETS CHANGE					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	TRANFERS					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

KPMG LLP Compu-Max 2552-10

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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	21,424,586		21,424,586	1
2	Subprovider IPF	2,354,952		2,354,952	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)	23,779,538		23,779,538	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,777,036		6,777,036	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
14.01	NEONATAL INTENSIVE CARE	25,085,671		25,085,671	14.01
14.02	PEDIATRIC INTENSIVE CARE	2,496,339		2,496,339	14.02
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	34,359,046		34,359,046	16
17	Total inpatient routine care services (sum of lines 10 and 16)	58,138,584		58,138,584	17
18	Ancillary services	229,620,168	205,210,193	434,830,361	18
19	Outpatient services				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)	287,758,752	205,210,193	492,968,945	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		164,167,279	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	-144,708		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-144,708	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		164,022,571	43

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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)	492,968,945	1
2	Less contractual allowances and discounts on patients' accounts	341,991,271	2
3	Net patient revenues (line 1 minus line 2)	150,977,674	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	164,022,571	4
5	Net income from service to patients (line 3 minus line 4)	-13,044,897	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)	11,398,481	24
24.01	Other (OTHER NON-OPERATING INCOME)	3,064,898	24.01
24.02	Other (PROVIDER TAX)	22,934,829	24.02
25	Total other income (sum of lines 6-24)	37,398,208	25
26	Total (line 5 plus line 25)	24,353,311	26
29	Net income (or loss) for the period (line 26 minus line 28)	24,353,311	29

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 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 CATHETERIZATIN							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

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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