

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 type="checkbox"/> Electronically filed cost report 2. <input checked="" 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.		Date: 11/28/2018 Time: 10:48
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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROCKFORD MEMORIAL HOSPITAL (14-0239) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		1,052,584	219,576			1
2	SUBPROVIDER - IPF		-13,806	-1			2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,038,778	219,575			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: 07 / 01 / 2017	To: 06 / 30 / 2018							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.	8,786	3,786		1,266	12,410	691	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 is 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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
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)(i) or (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)(i) or (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)	Y	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	Y			60
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.	1	60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.03
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.04
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 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))
		1	2	3	4	5
65						65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
		1	2	3	4	5
67						67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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**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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2			
105	Does this hospital qualify as a 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
						1
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110
		1	2			
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.					111

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-I, 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	
		Premiums	Paid Losses	Self Insurance		
118.01	List amounts of malpractice premiums and paid losses:	1,699,127			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	
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122	

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 in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1 Y	2 HB0764	140
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If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: MERCY ROCKFORD HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00450	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	N	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		Title V	Title XIX	
		Part A	Part B			
		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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
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. 1, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N			0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	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	
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)	Y			3

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
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)	N		N	
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)	Y	09/17/2018	Y	09/17/2018
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 relifed 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: TRACEY	Last name: HALBRADER	Title: REIMBURSEMENT SUPERVISOR	41
42	Employer: MERCY HEALTH			42
43	Phone number: 815-971-3342	E-mail Address: THALBRADER@MHEMAIL.ORG		43

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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	213	81,451			13,271	9,707	36,731	1
2	HMO and other (see instructions)						7,036	12,410		2
3	HMO IPF Subprovider						400	624		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)		213	81,451			13,271	9,707	36,731	7
8	Intensive Care Unit	31	21	7,665			2,000	149	4,033	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	52	18,980				2,049	14,352	11.01
11.02	PEDIATRIC INTENSIVE CARE	34.02	7	2,555				176	879	11.02
12	Other Special Care (specify)	35								12
13	Nursery	43						2,448	3,557	13
14	Total (see instructions)		293	110,651			15,271	14,529	59,552	14
15	CAH Visits									15
16	Subprovider - IPF	40	14	5,110			963	375	3,609	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							173	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		307							27
28	Observation Bed Days								6,704	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		12	4,380					3,557	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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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)					3,357	2,633	12,004	1
2	HMO and other (see instructions)					1,427	3,149		2
3	HMO IPF Subprovider						148		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)	0.39	1,600.44			3,357	2,633	12,004	14
15	CAH Visits								15
16	Subprovider - IPF		25.04			110	72	577	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)	0.39	1,625.48						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	112,324,433	-11,984,697	100,339,736	3,380,993.98	29.68	1
2							2
3							3
4		89,621		89,621	609.00	147.16	4
4.01							4.01
5		828		828	32.65	25.36	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		3,816,413	132,932	3,949,345	348,539.34	11.33	10
OTHER WAGES & RELATED COSTS							
11		2,233,983		2,233,983	26,816.58	83.31	11
12							12
13		2,607,111		2,607,111	43,151.00	60.42	13
14							14
14.01		17,110,002		17,110,002	398,427.00	42.94	14.01
14.02							14.02
15							15
16							16
WAGE-RELATED COSTS							
17		24,031,066		24,031,066			17
18							18
19		1,821,238		1,821,238			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
25.50		2,328,502		2,328,502			25.50
25.51							25.51
25.52							25.52
25.53							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26		833,554	-775,644	57,910	1,483.20	39.04	26
27		17,642,390	-14,947,901	2,694,489	175,743.00	15.33	27
28		268,737		268,737	1,393.55	192.84	28
29							29
30		2,507,492	343,449	2,850,941	109,400.08	26.06	30
31		103,011	51,217	154,228	8,568.18	18.00	31
32		1,950,293	63,693	2,013,986	138,965.93	14.49	32
33		21,253		21,253	1,236.95	17.18	33
34		2,323,307	-1,543,485	779,822	46,001.71	16.95	34
35		16,980		16,980	872.15	19.47	35
36			1,628,894	1,628,894	107,908.00	15.10	36
37							37
38		3,590,034	386,597	3,976,631	75,056.87	52.98	38
39		1,293,589	50,050	1,343,639	76,303.41	17.61	39
40		3,830,935	385,023	4,215,958	97,482.45	43.25	40
41		1,608,393	-410,806	1,197,587	44,812.93	26.72	41
42		358,935	-15,375	343,560	8,949.48	38.39	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	112,630,575	-11,984,697	100,645,878	3,384,463.98	29.74	1
2	Excluded area salaries (see instructions)	3,816,413	132,932	3,949,345	348,539.34	11.33	2
3	Subtotal salaries (line 1 minus line 2)	108,814,162	-12,117,629	96,696,533	3,035,924.64	31.85	3
4	Subtotal other wages & related costs (see instructions)	21,951,096		21,951,096	468,394.58	46.86	4
5	Subtotal wage-related costs (see instructions)	26,359,568		26,359,568		27.26%	5
6	Total (sum of lines 3 through 5)	157,124,826	-12,117,629	145,007,197	3,504,319.22	41.38	6
7	Total overhead cost (see instructions)	36,348,903	-14,784,288	21,564,615	894,177.89	24.12	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	5,415,113	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11,371,541	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	483,514	10
11	Life Insurance (If employee is owner or beneficiary)	54,854	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	538,520	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	232,983	16
	TAXES		
17	FICA-Employers Portion Only	7,232,456	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	63,000	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	460,323	23
24	Total Wage Related cost (Sum of lines 1-23)	25,852,304	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL 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)		0.205605	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		54,631,468	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 and/or supplemental payments from Medicaid?		N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		28,276,391	5
6	Medicaid charges		368,075,237	6
7	Medicaid cost (line 1 times line 6)		75,678,109	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,906,264	3,037,647	6,943,911	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	803,147	3,037,647	3,840,794	21
22	Payments received from patients for amounts previously written off as charity care	5,448	147,934	153,382	22
23	Cost of charity care (line 21 minus line 22)	797,699	2,889,713	3,687,412	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, charges for patient days beyond the indigent care program's length of stay limit			25
26	Total bad debt expense for the entire hospital complex (see instructions)		6,040,877	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,574,328	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,422,043	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,618,834	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,591,765	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		5,279,177	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,279,177	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				275,844	275,844	-70	275,774	1
2	00200	Cap Rel Costs-Mvble Equip				15,484,675	15,484,675		15,484,675	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	833,554	18,202,350	19,035,904	-4,155,530	14,880,374	-10,806	14,869,568	4
5	00500	Administrative & General	17,642,390	99,107,237	116,749,627	-13,409,715	103,339,912	-62,538,731	40,801,181	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,507,492	8,293,235	10,800,727	298,507	11,099,234	-39,105	11,060,129	7
8	00800	Laundry & Linen Service	103,011	84,801	187,812	51,217	239,029		239,029	8
9	00900	Housekeeping	1,950,293	831,021	2,781,314	63,693	2,845,007	-3,537	2,841,470	9
10	01000	Dietary	2,323,307	1,443,003	3,766,310	-1,679,493	2,086,817		2,086,817	10
11	01100	Cafeteria				1,764,902	1,764,902	-1,675,311	89,591	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	3,590,034	583,944	4,173,978	386,597	4,560,575	-25,127	4,535,448	13
14	01400	Central Services & Supply	1,293,589	1,106,029	2,399,618	-104,256	2,295,362		2,295,362	14
15	01500	Pharmacy	3,830,935	15,734,562	19,565,497	-14,351,597	5,213,900	-293,637	4,920,263	15
16	01600	Medical Records & Library	1,608,393	816,827	2,425,220	-456,419	1,968,801	-18,734	1,950,067	16
17	01700	Social Service	358,935	99,517	458,452	-84,661	373,791	-13,470	360,321	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				862,574	862,574		862,574	22
23	02300	PARAMDICAL ED PROGRAM XRAY	179,443	26,429	205,872		205,872	-25,790	180,082	23
23.01	02301	PASTORAL EDUCATION PROGRAM				107,595	107,595	-4,075	103,520	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	599,387	483,866	1,083,253	118,937	1,202,190	-298,596	903,594	23.02
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	20,711,352	4,750,949	25,462,301	-1,662,259	23,800,042	-86,927	23,713,115	30
31	03100	Intensive Care Unit	3,363,154	1,267,415	4,630,569	-482,229	4,148,340		4,148,340	31
34.01	03401	NEONATAL INTENSIVE CARE	8,275,875	2,246,812	10,522,687	-3,075,141	7,447,546	-14,800	7,432,746	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	1,049,529	184,395	1,233,924	27,523	1,261,447		1,261,447	34.02
40	04000	Subprovider - IPF	1,469,001	211,886	1,680,887	72,171	1,753,058		1,753,058	40
43	04300	Nursery				2,562,239	2,562,239		2,562,239	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	7,209,367	18,925,789	26,135,156	-15,497,723	10,637,433	-323,512	10,313,921	50
51	05100	Recovery Room	839,212	96,268	935,480	59,225	994,705		994,705	51
52	05200	Delivery Room & Labor Room	3,547,374	3,040,766	6,588,140	-506,696	6,081,444	-1,205,690	4,875,754	52
53	05300	Anesthesiology	409,780	2,677,348	3,087,128	-813,046	2,274,082	-1,534,994	739,088	53
54	05400	Radiology-Diagnostic	3,088,160	3,270,197	6,358,357	-2,589,091	3,769,266	-15,029	3,754,237	54
55	05500	Radiology-Therapeutic	1,136,195	479,081	1,615,276	-54,114	1,561,162		1,561,162	55
56	05600	Radioisotope	261,764	652,755	914,519		914,519		914,519	56
57	05700	CT Scan	837,222	415,037	1,252,259	-185,857	1,066,402		1,066,402	57
58	05800	MRI	609,869	187,060	796,929		796,929		796,929	58
59	05900	Cardiac Catheterization	1,005,084	4,585,569	5,590,653	-4,291,285	1,299,368		1,299,368	59
60	06000	Laboratory	5,451,816	13,046,057	18,497,873	169,140	18,667,013	-10,767,847	7,899,166	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.	129,594	1,137,924	1,267,518	13,204	1,280,722		1,280,722	63
64	06400	Intravenous Therapy	230,636	53,082	283,718	26,697	310,415		310,415	64
65	06500	Respiratory Therapy	2,298,598	1,216,378	3,514,976	-347,423	3,167,553	-130	3,167,423	65
66	06600	Physical Therapy	1,662,907	230,059	1,892,966	7,270	1,900,236	-954	1,899,282	66
69	06900	Electrocardiology	1,051,885	527,805	1,579,690		1,579,690		1,579,690	69
70	07000	Electroencephalography	583,803	218,507	802,310	47,786	850,096		850,096	70
71	07100	Medical Supplies Charged to Patients				16,900,040	16,900,040		16,900,040	71
72	07200	Impl. Dev. Charged to Patients				13,307,278	13,307,278		13,307,278	72
73	07300	Drugs Charged to Patients				14,736,620	14,736,620		14,736,620	73
74	07400	Renal Dialysis		736,870	736,870	-9,383	727,487		727,487	74
76	03340	GI LAB	540,605	707,649	1,248,254	-487,448	760,806	-5,714	755,092	76
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	648,273	263,105	911,378	-129,007	782,371		782,371	90.01
90.02	09001	ANTENATAL TEST CENTER	614,901	284,233	899,134	5,880	905,014	-43,225	861,789	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	250,917	23,928	274,845	8,950	283,795		283,795	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	287,327	205,216	492,543	-92,403	400,140		400,140	90.04
90.05	09005	GENETIC SERVICES	344,947	37,196	382,143	8,950	391,093		391,093	90.05
91	09100	Emergency	6,025,941	2,454,400	8,480,341	-662,749	7,817,592	-813	7,816,779	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	973,736	586,344	1,560,080	56,408	1,616,488	-1,056,250	560,238	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30

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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	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	111,729,587	211,532,901	323,262,488	2,296,397	325,558,885	-80,002,874	245,556,011	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		1,540	1,540		1,540		1,540	192
193.01	19301	BELOIT HEART STANDBY	34,812	4,440	39,252	7,950	47,202		47,202	193.01
194	07950	GUEST CENTER	63,421	335,631	399,052		399,052		399,052	194
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER								194.01
194.02	07951	COMMUNITY SERVICES	394,440	2,691,253	3,085,693	-2,344,507	741,186		741,186	194.02
194.04	07952	AUXILIARY	102,173	291,729	393,902	40,160	434,062		434,062	194.04
194.08	07955	DIALYSIS RENTED SPACE								194.08
200		TOTAL (sum of lines 118-199)	112,324,433	214,857,494	327,181,927		327,181,927	-80,002,874	247,179,053	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		14,736,620	1
500	Total reclassifications					14,736,620	500
	Code Letter - A						
1	SHARED DIETARY EXPENSES	E	Cafeteria	11	1,628,894	136,008	1
500	Total reclassifications				1,628,894	136,008	500
	Code Letter - E						
1	RECLASS MED SUPPLIES CHGD PAT	F	Medical Supplies Charged to P	71		16,900,040	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
500	Total reclassifications					16,900,040	500
	Code Letter - F						
1	NURSERY COSTS	G	Nursery	43	682,610	45,134	1
2			Nursery	43	1,710,058	124,437	2
500	Total reclassifications				2,392,668	169,571	500
	Code Letter - G						
1	DEPARTMENTAL DEPRECIATION	H	Cap Rel Costs-Mvble Equip	2		15,484,675	1
2							2
500	Total reclassifications					15,484,675	500
	Code Letter - H						
1	INSURANCE RECLASS	I	Cap Rel Costs-Bldg & Fixt	1		275,844	1
2							2
3							3
500	Total reclassifications					275,844	500
	Code Letter - I						
1	PASTORAL EDUCATION PROGRAM	J	PASTORAL EDUCATION PROGRAM	23.01	72,211	35,384	1
500	Total reclassifications				72,211	35,384	500
	Code Letter - J						
1	IMPLANTS	K	Impl. Dev. Charged to Patient	72		13,307,278	1
2							2
3							3
500	Total reclassifications					13,307,278	500
	Code Letter - K						
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4		833,720	1
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5		10,425,175	2
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7		25,235	3
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16		410,806	4
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17		48,069	5
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02		241,692	6
500	Total reclassifications					11,984,697	500
	Code Letter - L						
1	SHARED SERVICES DIRECT COST ASSIGNE	M					1
2	SHARED SERVICES DIRECT COST ASSIGNE	M	Administrative & General	5		7,199,955	2
3							3
4							4
5							5
500	Total reclassifications					7,199,955	500
	Code Letter - M						

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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	
1	INTERNS AND RESIDENTS	O	I&R Services-Other Prgm Costs	22	53,987	365,386	1
2			I&R Services-Other Prgm Costs	22	415,570	27,631	2
500	Total reclassifications				469,557	393,017	500
	Code Letter - O						
1	DIRECTOR AND MANAGER	P	Employee Benefits Department	4	58,076		1
2			Operation of Plant	7	368,684		2
3			Laundry & Linen Service	8	51,217		3
4			Housekeeping	9	63,693		4
5			Dietary	10	85,409		5
6			Nursing Administration	13	386,597		6
7			Central Services & Supply	14	50,050		7
8			Pharmacy	15	385,023		8
9			Social Service	17	32,694		9
10			PARAMED EDUC EMT PROGRAM	23.02	118,937		10
11			Adults & Pediatrics	30	868,662		11
12			Intensive Care Unit	31	159,676		12
13			NEONATAL INTENSIVE CARE	34.01	95,341		13
14			PEDIATRIC INTENSIVE CARE	34.02	95,716		14
15			Subprovider - IPF	40	78,958		15
16			Operating Room	50	191,723		16
17			Recovery Room	51	59,225		17
18			Delivery Room & Labor Room	52	69,475		18
19			Anesthesiology	53	41,537		19
20			Radiology-Diagnostic	54	76,450		20
21			Radiology-Therapeutic	55	5,446		21
22			Cardiac Catheterization	59	3,672		22
23			Laboratory	60	169,674		23
24			Blood Storing, Processing & T	63	13,204		24
25			Intravenous Therapy	64	33,587		25
26			Respiratory Therapy	65	43,748		26
27			Physical Therapy	66	8,950		27
28			Electroencephalography	70	47,786		28
29			GI LAB	76	50,145		29
30			PAIN CENTER	90.01	33,510		30
31			ANTENATAL TEST CENTER	90.02	5,880		31
32			CHILD PSYCHIATRIC CLINIC	90.03	8,950		32
33			GENETIC SERVICES	90.05	8,950		33
34			Emergency	91	105,795		34
35			Ambulance Services	95	56,408		35
36			BELOIT HEART STANDBY	193.01	7,950		36
37			AUXILIARY	194.04	40,160		37
500	Total reclassifications				3,980,958		500
	Code Letter - P						
	GRAND TOTAL (Increases)				8,544,288	80,623,089	

(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		14,736,620	1
500	Total reclassifications					14,736,620	500
	Code letter - A						
1	SHARED DIETARY EXPENSES	E	Dietary	10	1,628,894	136,008	1
500	Total reclassifications				1,628,894	136,008	500
	Code letter - E						
1	RECLASS MED SUPPLIES CHGD PAT	F					1
2			Central Services & Supply	14		154,306	2
3			Adults & Pediatrics	30		1,703,844	3
4			Intensive Care Unit	31		641,905	4
5			NEONATAL INTENSIVE CARE	34.01		1,335,987	5
6			PEDIATRIC INTENSIVE CARE	34.02		68,193	6
7			Subprovider - IPF	40		6,787	7
8			Operating Room	50		6,338,522	8
9			Delivery Room & Labor Room	52		576,171	9
10			Anesthesiology	53		854,583	10
11			Radiology-Diagnostic	54		2,264,605	11
12			Radiology-Therapeutic	55		59,560	12
13			CT Scan	57		185,857	13
14			Cardiac Catheterization	59		739,539	14
15			Intravenous Therapy	64		6,890	15
16			Respiratory Therapy	65		391,171	16
17			Physical Therapy	66		1,680	17
18			Renal Dialysis	74		9,383	18
19			GI LAB	76		537,593	19
20			PAIN CENTER	90.01		162,517	20
21			SPECIAL SURGICAL SERVICES	90.04		92,403	21
22			Emergency	91		768,544	22
500	Total reclassifications					16,900,040	500
	Code letter - F						
1	NURSERY COSTS	G	Adults & Pediatrics	30	682,610	45,134	1
2			NEONATAL INTENSIVE CARE	34.01	1,710,058	124,437	2
500	Total reclassifications				2,392,668	169,571	500
	Code letter - G						
1	DEPARTMENTAL DEPRECIATION	H					9
2			Administrative & General	5		15,484,675	2
500	Total reclassifications					15,484,675	500
	Code letter - H						
1	INSURANCE RECLASS	I	Administrative & General	5		273,201	12
2			Laboratory	60		534	2
3			COMMUNITY SERVICES	194.02		2,109	3
500	Total reclassifications					275,844	500
	Code letter - I						
1	PASTORAL EDUCATION PROGRAM	J	Administrative & General	5	72,211	35,384	1
500	Total reclassifications				72,211	35,384	500
	Code letter - J						
1	IMPLANTS	K	Operating Room	50		9,350,924	1
2			Radiology-Diagnostic	54		400,936	2
3			Cardiac Catheterization	59		3,555,418	3
500	Total reclassifications					13,307,278	500
	Code letter - K						
1	SHARED SERVICES SALARY RECLASS	L	Employee Benefits Department	4	833,720		1
2	SHARED SERVICES SALARY RECLASS	L	Administrative & General	5	10,425,175		2
3	SHARED SERVICES SALARY RECLASS	L	Operation of Plant	7	25,235		3
4	SHARED SERVICES SALARY RECLASS	L	Medical Records & Library	16	410,806		4
5	SHARED SERVICES SALARY RECLASS	L	Social Service	17	48,069		5
6	SHARED SERVICES SALARY RECLASS	L	COMMUNITY SERVICES	194.02	241,692		6
500	Total reclassifications				11,984,697		500
	Code letter - L						
1	SHARED SERVICES DIRECT COST ASSIGNE	M	Employee Benefits Department	4		4,213,606	1
2	SHARED SERVICES DIRECT COST ASSIGNE	M	Operation of Plant	7		70,177	2
3			Medical Records & Library	16		456,419	3
4			Social Service	17		117,355	4
5			COMMUNITY SERVICES	194.02		2,342,398	5
500	Total reclassifications					7,199,955	500
	Code letter - M						

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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	INTERNS AND RESIDENTS	O	Administrative & General	5	469,557	293,684	1
2			Adults & Pediatrics	30		99,333	2
500	Total reclassifications Code letter - O				469,557	393,017	500
1	DIRECTOR AND MANAGER	P	Administrative & General	5	3,980,958		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
34							34
35							35
36							36
37							37
500	Total reclassifications Code letter - P				3,980,958		500
	GRAND TOTAL (Decreases)				20,528,985	68,638,392	

(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	8,437,914					8,437,914		1
2	Land Improvements	7,886,613	66,636		66,636		7,953,249		2
3	Buildings and Fixtures	56,624,062	188,514		188,514		56,812,576		3
4	Building Improvements								4
5	Fixed Equipment	138,535,550	1,132,899		1,132,899		139,668,449		5
6	Movable Equipment	137,631,218				233,285	137,397,933		6
7	HIT-designated Assets	26,960,052				16,297	26,943,755		7
8	Subtotal (sum of lines 1-7)	376,075,409	1,388,049		1,388,049	249,582	377,213,876		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	376,075,409	1,388,049		1,388,049	249,582	377,213,876		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	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	212,872,188		212,872,188	0.564328					1
2	Cap Rel Costs-Mvble Equip	164,341,688		164,341,688	0.435672					2
3	Total (sum of lines 1-2)	377,213,876		377,213,876	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	-70			275,844			275,774	1
2	Cap Rel Costs-Mvble Equip	15,484,675						15,484,675	2
3	Total (sum of lines 1-2)	15,484,605			275,844			15,760,449	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			
				COST CENTER	LINE#	Wkst. A-7 Ref.	
		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	-4,026	Administrative & General	5	8	
9	Parking lot (chapter 21)					9	
10	Provider-based physician adjustment	Wkst A-8-2	-54,121,804			10	
11	Sale of scrap, waste, etc. (chapter 23)					11	
12	Related organization transactions (chapter 10)	Wkst A-8-1	6,420,800			12	
13	Laundry and linen service					13	
14	Cafeteria - employees and guests	B	-1,646,440	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	-18,734	Medical Records & Library	16	18	
19	Nursing and allied health education (tuition, fees, books, etc.)					19	
20	Vending machines	B	-28,871	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	-8,645	Employee Benefits Department	4	33.01	
33.02	MISC REV - ADMIN	B	-1,362,352	Administrative & General	5	33.02	
33.03	MISC REV - PLANT	B	-27,057	Operation of Plant	7	33.03	
33.04	MISC REV	B	-13,470	Social Service	17	33.04	
33.05	MISC REV - PARAMED XRAY ED	B	-25,790	PARAMDICAL ED PROGRAM XRAY	23	33.05	
33.06	MISC REV - PASTORAL ED	B	-4,075	PASTORAL EDUCATION PROGRAM	23.01	33.06	
33.07	MISC REV - PARAMED EMT ED	B	-298,596	PARAMED EDUC EMT PROGRAM	23.02	33.07	
33.08	MISC REV - NICU	B	-14,800	NEONATAL INTENSIVE CARE	34.01	33.08	
33.09	MISC REV - XRAYS	B	-1,567	Radiology-Diagnostic	54	33.09	
33.10	MISC REV - REF LAB	B	-10,379,820	Laboratory	60	33.10	
33.14	MISC REVENUE	B	-1,056,250	Ambulance Services	95	33.14	
33.16	MISC REV - PHARM	B	-293,637	Pharmacy	15	33.16	
33.17	MISC REV	B	-750	Operating Room	50	33.17	
33.18	MISC REV	B	-130	Respiratory Therapy	65	33.18	
33.19	MISC REV	B	-954	Physical Therapy	66	33.19	
34						34	
34.01	INTEREST - ADMIN	A	-2,471,301	Administrative & General	5	34.01	
34.02	INTEREST - SURG	A	-18,370	Operating Room	50	34.02	
35						35	
35.01	PATIENT PHONE - BLD & FIXT	A	-70	Cap Rel Costs-Bldg & Fixt	1	9	35.01
35.03	PATIENT PHONE - EMP BEN	A	-2,161	Employee Benefits Department	4	35.03	
35.04	PATIENT PHONE - ADMIN	A	-22,614	Administrative & General	5	35.04	
35.05	PATIENT PHONE - PLANT	A	-12,048	Operation of Plant	7	35.05	
35.06	PATIENT PHONE - HOUSEKEEP	A	-3,537	Housekeeping	9	35.06	
36						36	
37						37	
37.01	LOBBYING	A	-36,484	Administrative & General	5	37.01	
38						38	
39						39	
39.01	TAXES - PROV ASSESS	A	-14,417,543	Administrative & General	5	39.01	
40						40	
41						41	

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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. 5
				COST CENTER	LINE#		
		1	2	3	4		
41.02	PB TO CLINIC	A	-126,064	Operating Room	50		41.02
41.03	PB TO CLINIC	A	-5,714	GI LAB	76		41.03
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)		-80,002,874				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							1
2	5	Administrative & General	MNGMT FEE & SHARED SVCS	32,741,948	26,321,148	6,420,800	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			32,741,948	26,321,148	6,420,800	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			
				Name	Percentage of Ownership	Type of Business	
	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										1
2	5	Administrative & Gen PROFESSIONAL FE	52,774,683	50,645,211	2,129,472	211,500	34,074	3,464,736	173,237	2
3	13	Nursing Administrati PROFESSIONAL FE	106,067	25,127	80,940	211,500	5,112	519,802	25,990	3
4										4
5	30	Adults & Pediatrics PROFESSIONAL FE	86,927	86,927		179,000				5
6										6
7	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE	14,423		14,423	197,500	474	45,007	2,250	7
8										8
9										9
10	50	Operating Room PROFESSIONAL FE	437,759	134,651	303,108	246,400	2,190	259,431	12,972	10
11	52	Delivery Room & Labo PROFESSIONAL FE	1,205,690	1,205,690						11
12	53	Anesthesiology PROFESSIONAL FE	1,568,245	1,534,994	33,251	239,400	504	58,009	2,900	12
13	60	Laboratory PROFESSIONAL FE	388,027	388,027						13
14	90.02	ANTENATAL TEST CENTE AGGREGATE	43,225	43,225						14
15	91	Emergency PROFESSIONAL FE	100,000		100,000	200,300	1,030	99,187	4,959	15
16	54	Radiology-Diagnostic AGGREGATE	13,462	13,462						16
17										17
18										18
19										19
20										20
200		TOTAL	56,738,508	54,077,314	2,661,194		43,384	4,446,172	222,308	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										1
2	5	Administrative & Gen PROFESSIONAL FE					3,464,736		50,645,211	2
3	13	Nursing Administrati PROFESSIONAL FE					519,802		25,127	3
4										4
5	30	Adults & Pediatrics PROFESSIONAL FE							86,927	5
6										6
7	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE					45,007			7
8										8
9										9
10	50	Operating Room PROFESSIONAL FE					259,431	43,677	178,328	10
11	52	Delivery Room & Labo PROFESSIONAL FE							1,205,690	11
12	53	Anesthesiology PROFESSIONAL FE					58,009		1,534,994	12
13	60	Laboratory PROFESSIONAL FE							388,027	13
14	90.02	ANTENATAL TEST CENTE AGGREGATE							43,225	14
15	91	Emergency PROFESSIONAL FE					99,187	813	813	15
16	54	Radiology-Diagnostic AGGREGATE							13,462	16
17										17
18										18
19										19
20										20
200		TOTAL					4,446,172	44,490	54,121,804	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	275,774	275,774					1
2	Cap Rel Costs-Mvble Equip	15,484,675		15,484,675				2
4	Employee Benefits Department	14,869,568	4,462	27,643	14,901,673			4
5	Administrative & General	40,801,181	65,518	4,193,011	400,396	45,460,106	45,460,106	5
6	Maintenance & Repairs							6
7	Operation of Plant	11,060,129	30,414	1,363,467	423,644	12,877,654	2,902,160	7
8	Laundry & Linen Service	239,029	1,581	5,301	22,918	268,829	60,584	8
9	Housekeeping	2,841,470	3,421	38,687	299,274	3,182,852	717,300	9
10	Dietary	2,086,817	3,886	21,130	115,880	2,227,713	502,046	10
11	Cafeteria	89,591	9,117	49,567	242,050	390,325	87,965	11
12	Maintenance of Personnel							12
13	Nursing Administration	4,535,448	2,387	24,430	590,919	5,153,184	1,161,342	13
14	Central Services & Supply	2,295,362	4,670	416,329	199,662	2,916,023	657,167	14
15	Pharmacy	4,920,263	2,693	361,910	626,483	5,911,349	1,332,205	15
16	Medical Records & Library	1,950,067	2,298	7,583	177,959	2,137,907	481,807	16
17	Social Service	360,321	670		51,052	412,043	92,860	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	862,574	1,279		69,775	933,628	210,406	22
23	PARAMDICAL ED PROGRAM XRAY	180,082	243	91	26,665	207,081	46,669	23
23.01	PASTORAL EDUCATION PROGRAM	103,520	261		10,730	114,511	25,807	23.01
23.02	PARAMED EDUC EMT PROGRAM	903,594	4,394	145,522	106,742	1,160,252	261,479	23.02
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	23,713,115	42,445	1,442,870	3,105,307	28,303,737	6,378,561	30
31	Intensive Care Unit	4,148,340	3,615	234,874	523,485	4,910,314	1,106,608	31
34.01	NEONATAL INTENSIVE CARE	7,432,746	4,608	223,549	989,835	8,650,738	1,949,565	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,261,447	1,321	13,348	170,181	1,446,297	325,943	34.02
40	Subprovider - IPF	1,753,058	4,711	54,459	230,024	2,042,252	460,250	40
43	Nursery	2,562,239	2,613	114,487	355,546	3,034,885	683,954	43
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	10,313,921	13,556	1,549,314	1,099,787	12,976,578	2,924,454	50
51	Recovery Room	994,705	1,165	7,490	133,506	1,136,866	256,209	51
52	Delivery Room & Labor Room	4,875,754	5,079	192,523	537,457	5,610,813	1,264,475	52
53	Anesthesiology	739,088	335	92,197	67,065	898,685	202,531	53
54	Radiology-Diagnostic	3,754,237	4,682	1,012,404	470,255	5,241,578	1,181,263	54
55	Radiology-Therapeutic	1,561,162	5,771	1,156,168	169,646	2,892,747	651,921	55
56	Radioisotope	914,519	529	1,126	38,898	955,072	215,239	56
57	CT Scan	1,066,402	1,074	141,847	124,410	1,333,733	300,575	57
58	MRI	796,929	2,120	122,593	90,625	1,012,267	228,129	58
59	Cardiac Catheterization	1,299,368	2,022	340,866	149,899	1,792,155	403,887	59
60	Laboratory	7,899,166	7,157	591,991	835,342	9,333,656	2,103,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,280,722	270	2,719	21,219	1,304,930	294,084	63
64	Intravenous Therapy	310,415	370	1,989	39,263	352,037	79,336	64
65	Respiratory Therapy	3,167,423	2,057	201,609	348,068	3,719,157	838,164	65
66	Physical Therapy	1,899,282	1,997	983	248,435	2,150,697	484,690	66
69	Electrocardiology	1,579,690	4,003	20,656	156,308	1,760,657	396,789	69
70	Electroencephalography	850,096	2,011	133,071	93,853	1,079,031	243,175	70
71	Medical Supplies Charged to Patients	16,900,040				16,900,040	3,808,661	71
72	Impl. Dev. Charged to Patients	13,307,278				13,307,278	2,998,981	72
73	Drugs Charged to Patients	14,736,620				14,736,620	3,321,104	73
74	Renal Dialysis	727,487	638	1,611		729,736	164,456	74
76	GI LAB	755,092	1,681	289,893	87,784	1,134,450	255,664	76
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	782,371	2,084	153,738	101,312	1,039,505	234,267	90.01
90.02	ANTENATAL TEST CENTER	861,789	1,961	171,176	92,247	1,127,173	254,024	90.02
90.03	CHILD PSYCHIATRIC CLINIC	283,795	618		38,616	323,029	72,799	90.03
90.04	SPECIAL SURGICAL SERVICES	400,140	1,284	20,078	42,696	464,198	104,614	90.04
90.05	GENETIC SERVICES	391,093	794	18,976	52,588	463,451	104,445	90.05
91	Emergency	7,816,779	6,171	504,265	911,164	9,238,379	2,081,998	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	560,238	2,198	3,024	153,077	718,537	161,932	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								

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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	
118	SUBTOTALS (sum of lines 1-117)	245,556,011	268,234	15,470,565	14,842,047	245,474,735	45,076,014	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,540	196			1,736	391	192
193.01	BELOIT HEART STANDBY	47,202			6,354	53,556	12,070	193.01
194	GUEST CENTER	399,052	2,001	8,260	9,424	418,737	94,368	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	741,186	1,487	5,582	22,698	770,953	173,745	194.02
194.04	AUXILIARY	434,062	3,856	268	21,150	459,336	103,518	194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	247,179,053	275,774	15,484,675	14,901,673	247,179,053	45,460,106	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	15,779,814						7
8	Laundry & Linen Service	144,437	473,850					8
9	Housekeeping	312,603		4,212,755				9
10	Dietary	366,167		96,093	3,192,019			10
11	Cafeteria	821,972		225,427		1,525,689		11
12	Maintenance of Personnel							12
13	Nursing Administration	218,130		59,029		41,008	6,632,693	13
14	Central Services & Supply	426,658	2,305	115,460		41,678		14
15	Pharmacy	246,043		66,583		53,256		15
16	Medical Records & Library	209,934		56,811		24,475		16
17	Social Service	61,176		16,555		4,886		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	78,185		31,635		1,534		22
23	PARAMDICAL ED PROGRAM XRAY	22,187		6,004		92,128		23
23.01	PASTORAL EDUCATION PROGRAM	19,512		6,459		37,133		23.01
23.02	PARAMED EDUC EMT PROGRAM	190,285		108,649		12,647	823	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,804,769	170,293	1,049,498	2,608,269	332,626	3,035,196	30
31	Intensive Care Unit	330,264	14,860	89,375	259,980	56,745	73,498	31
34.01	NEONATAL INTENSIVE CARE	452,925	9,758	113,948		86,106	578,102	34.01
34.02	PEDIATRIC INTENSIVE CARE	120,707		32,665	56,658	14,794	55,158	34.02
40	Subprovider - IPF	430,430	4,231	116,481	232,648	28,452	64,305	40
43	Nursery	251,358	7,872	64,607		38,531	312,651	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,277,298	67,909	335,190		102,161	549,426	50
51	Recovery Room	106,407	3,727	28,796		9,897	123,670	51
52	Delivery Room & Labor Room	464,070	47,762	125,585		49,643	359,553	52
53	Anesthesiology	30,623		8,287		7,636	194,332	53
54	Radiology-Diagnostic	427,789	19,742	115,767		55,995	44,638	54
55	Radiology-Therapeutic	527,269	1,978	142,688		17,033	103,889	55
56	Radioisotope	48,317	6	13,075		3,841		56
57	CT Scan	98,109		26,550		13,056	183	57
58	MRI	193,748	3,912	52,431		9,124	1,006	58
59	Cardiac Catheterization	184,729	5,735	49,991		14,521	8,415	59
60	Laboratory	653,943	3,834	176,968		123,568		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	24,690		6,682		2,500		63
64	Intravenous Therapy	33,777		9,141		3,602	434	64
65	Respiratory Therapy	187,953	40	50,863		40,678	434	65
66	Physical Therapy	182,501	234	49,388		23,702		66
69	Electrocardiology	365,721		98,970		17,305	45,279	69
70	Electroencephalography	183,769	70	49,731		10,363		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	58,262		15,767				74
76	GI LAB	153,627	8,599	41,574		10,340	49,532	76
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	190,422	5,255	51,531		13,317	58,428	90.01
90.02	ANTENATAL TEST CENTER	179,174	6,200	48,487		9,749	3,636	90.02
90.03	CHILD PSYCHIATRIC CLINIC	56,444	67	15,275		2,704		90.03
90.04	SPECIAL SURGICAL SERVICES	117,312		31,747		4,181	14,979	90.04
90.05	GENETIC SERVICES	72,527	65	19,627		4,954		90.05
91	Emergency	563,824	87,573	152,580	34,464	89,787	708,221	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	200,812	61	54,343		12,692	246,905	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)	15,090,859	472,088	4,026,313	3,192,019	1,518,348	6,632,693	118
	NONREIMBURSABLE COST CENTERS							

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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	
192	Physicians' Private Offices	17,935		4,853				192
193.01	BELOIT HEART STANDBY					205		193.01
194	GUEST CENTER	182,843	1,762	49,480		1,159		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	135,864		36,767		2,068		194.02
194.04	AUXILIARY	352,313		95,342		3,909		194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,779,814	473,850	4,212,755	3,192,019	1,525,689	6,632,693	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	I&R PROGRAM COSTS	PARAMEDICA EDUCATION XRAY	
		14	15	16	17	22	23	
	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	4,159,291						14
15	Pharmacy	6,003	7,615,439					15
16	Medical Records & Library			2,910,934				16
17	Social Service				587,520			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					1,255,388		22
23	PARAMEDICAL ED PROGRAM XRAY						374,069	23
23.01	PASTORAL EDUCATION PROGRAM							23.01
23.02	PARAMED EDUC EMT PROGRAM	493	40,573					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	263	108,487	132,310	500,380	1,255,388		30
31	Intensive Care Unit		34,249	34,709				31
34.01	NEONATAL INTENSIVE CARE	4	26,872	111,271	7,662			34.01
34.02	PEDIATRIC INTENSIVE CARE		12,123	10,977	2,179			34.02
40	Subprovider - IPF		5	12,255	73,017			40
43	Nursery			48,713	4,282			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27	69,469	169,493				50
51	Recovery Room	2,684	5,672	20,311				51
52	Delivery Room & Labor Room		32,558	52,275				52
53	Anesthesiology	14	99,722	32,801				53
54	Radiology-Diagnostic	3,309	42,693	129,056			374,069	54
55	Radiology-Therapeutic	348	517	24,192				55
56	Radioisotope	45,305	314	25,545				56
57	CT Scan	982	3,458	161,156				57
58	MRI	1,240	3,737	62,463				58
59	Cardiac Catheterization		59,667	57,476				59
60	Laboratory	541,892	31	192,528				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	123,356		26,282				63
64	Intravenous Therapy		7,538	105,839				64
65	Respiratory Therapy	39	578	80,916				65
66	Physical Therapy			18,831				66
69	Electrocardiology	35,588	4,880	82,270				69
70	Electroencephalography	5,129		22,353				70
71	Medical Supplies Charged to Patients	1,895,836		431,547				71
72	Impl. Dev. Charged to Patients	1,492,797		220,679				72
73	Drugs Charged to Patients		6,877,808	424,780				73
74	Renal Dialysis		200	3,140				74
76	GI LAB		4,592	20,696				76
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		9,909	26,989				90.01
90.02	ANTENATAL TEST CENTER	1,456		32,959				90.02
90.03	CHILD PSYCHIATRIC CLINIC	16		775				90.03
90.04	SPECIAL SURGICAL SERVICES		14,596	7,671				90.04
90.05	GENETIC SERVICES	104		914				90.05
91	Emergency	198	153,996	124,921				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	2,049	484	1,841				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)	4,159,132	7,614,728	2,910,934	587,520	1,255,388	374,069	118
	NONREIMBURSABLE COST CENTERS							

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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	I&R PROGRAM COSTS	PARAMEDICA EDUCATION XRAY	
		14	15	16	17	22	23	
192	Physicians' Private Offices	68						192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER							194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	91	711					194.02
194.04	AUXILIARY							194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,159,291	7,615,439	2,910,934	587,520	1,255,388	374,069	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	23.01	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	203,422					23.01
23.02	PARAMED EDUC EMT PROGRAM		1,775,201				23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	128,386	47,154	47,855,317	-1,255,388	46,599,929	30
31	Intensive Care Unit	14,182		6,924,784		6,924,784	31
34.01	NEONATAL INTENSIVE CARE	37,130	94,308	12,118,389		12,118,389	34.01
34.02	PEDIATRIC INTENSIVE CARE	4,048		2,081,549		2,081,549	34.02
40	Subprovider - IPF	11,668		3,475,994		3,475,994	40
43	Nursery	8,008		4,454,861		4,454,861	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		246,864	18,718,869		18,718,869	50
51	Recovery Room			1,694,239		1,694,239	51
52	Delivery Room & Labor Room		47,154	8,053,888		8,053,888	52
53	Anesthesiology			1,474,631		1,474,631	53
54	Radiology-Diagnostic			7,635,899		7,635,899	54
55	Radiology-Therapeutic			4,362,582		4,362,582	55
56	Radioisotope			1,306,714		1,306,714	56
57	CT Scan			1,937,802		1,937,802	57
58	MRI			1,568,057		1,568,057	58
59	Cardiac Catheterization			2,576,576		2,576,576	59
60	Laboratory			13,129,890		13,129,890	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.			1,782,524		1,782,524	63
64	Intravenous Therapy			591,704		591,704	64
65	Respiratory Therapy		36,059	4,954,881		4,954,881	65
66	Physical Therapy			2,910,043		2,910,043	66
69	Electrocardiology			2,807,459		2,807,459	69
70	Electroencephalography			1,593,621		1,593,621	70
71	Medical Supplies Charged to Patients			23,036,084		23,036,084	71
72	Impl. Dev. Charged to Patients			18,019,735		18,019,735	72
73	Drugs Charged to Patients			25,360,312		25,360,312	73
74	Renal Dialysis			971,561		971,561	74
76	GI LAB			1,679,074		1,679,074	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER			1,629,623		1,629,623	90.01
90.02	ANTENATAL TEST CENTER			1,662,858		1,662,858	90.02
90.03	CHILD PSYCHIATRIC CLINIC			471,109		471,109	90.03
90.04	SPECIAL SURGICAL SERVICES			759,298		759,298	90.04
90.05	GENETIC SERVICES			666,087		666,087	90.05
91	Emergency		1,303,662	14,539,603		14,539,603	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services			1,399,656		1,399,656	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)	203,422	1,775,201	244,205,273	-1,255,388	242,949,885	118
	NONREIMBURSABLE COST CENTERS						

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	
		23.01	23.02	24	25	26	
192	Physicians' Private Offices			24,983		24,983	192
193.01	BELOIT HEART STANDBY			65,831		65,831	193.01
194	GUEST CENTER			748,349		748,349	194
194.01	OTHER NONREIMBURSEABLE COST CENTER						194.01
194.02	COMMUNITY SERVICES			1,120,199		1,120,199	194.02
194.04	AUXILIARY			1,014,418		1,014,418	194.04
194.08	DIALYSIS RENTED SPACE						194.08
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	203,422	1,775,201	247,179,053	-1,255,388	245,923,665	202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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		4,462	27,643	32,105	32,105		4
5	Administrative & General	2,042,064	65,518	4,193,011	6,300,593	862	6,301,455	5
6	Maintenance & Repairs							6
7	Operation of Plant	5,382	30,414	1,363,467	1,399,263	912	402,285	7
8	Laundry & Linen Service		1,581	5,301	6,882	49	8,398	8
9	Housekeeping	2,068	3,421	38,687	44,176	644	99,429	9
10	Dietary	1,770	3,886	21,130	26,786	250	69,592	10
11	Cafeteria	3,974	9,117	49,567	62,658	521	12,193	11
12	Maintenance of Personnel							12
13	Nursing Administration	14,452	2,387	24,430	41,269	1,273	160,980	13
14	Central Services & Supply	379,888	4,670	416,329	800,887	430	91,094	14
15	Pharmacy	7,428	2,693	361,910	372,031	1,349	184,665	15
16	Medical Records & Library	1,451	2,298	7,583	11,332	383	66,786	16
17	Social Service	298	670		968	110	12,872	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	126	1,279		1,405	150	29,166	22
23	PARAMDICAL ED PROGRAM XRAY	4,454	243	91	4,788	57	6,469	23
23.01	PASTORAL EDUCATION PROGRAM	187	261		448	23	3,577	23.01
23.02	PARAMED EDUC EMT PROGRAM	10,000	4,394	145,522	159,916	230	36,245	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	45,246	42,445	1,442,870	1,530,561	6,703	884,138	30
31	Intensive Care Unit	2,846	3,615	234,874	241,335	1,127	153,393	31
34.01	NEONATAL INTENSIVE CARE	8,018	4,608	223,549	236,175	2,132	270,240	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,220	1,321	13,348	15,889	366	45,181	34.02
40	Subprovider - IPF	5,213	4,711	54,459	64,383	495	63,798	40
43	Nursery	2,584	2,613	114,487	119,684	766	94,807	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,385	13,556	1,549,314	1,575,255	2,368	405,375	50
51	Recovery Room		1,165	7,490	8,655	287	35,515	51
52	Delivery Room & Labor Room	4,674	5,079	192,523	202,276	1,157	175,276	52
53	Anesthesiology	2,220	335	92,197	94,752	144	28,074	53
54	Radiology-Diagnostic	4,495	4,682	1,012,404	1,021,581	1,013	163,742	54
55	Radiology-Therapeutic	3,676	5,771	1,156,168	1,165,615	365	90,367	55
56	Radioisotope	207	529	1,126	1,862	84	29,835	56
57	CT Scan	749	1,074	141,847	143,670	268	41,664	57
58	MRI	632	2,120	122,593	125,345	195	31,622	58
59	Cardiac Catheterization		2,022	340,866	342,888	323	55,985	59
60	Laboratory	28,222	7,157	591,991	627,370	1,799	291,574	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	655	270	2,719	3,644	46	40,765	63
64	Intravenous Therapy	582	370	1,989	2,941	85	10,997	64
65	Respiratory Therapy	24,488	2,057	201,609	228,154	750	116,183	65
66	Physical Therapy	6,052	1,997	983	9,032	535	67,186	66
69	Electrocardiology	3,690	4,003	20,656	28,349	337	55,001	69
70	Electroencephalography	3,261	2,011	133,071	138,343	202	33,708	70
71	Medical Supplies Charged to Patients						527,940	71
72	Impl. Dev. Charged to Patients						415,706	72
73	Drugs Charged to Patients						460,357	73
74	Renal Dialysis		638	1,611	2,249		22,796	74
76	GI LAB	50,453	1,681	289,893	342,027	189	35,439	76
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	4,990	2,084	153,738	160,812	218	32,473	90.01
90.02	ANTENATAL TEST CENTER	3,559	1,961	171,176	176,696	199	35,212	90.02
90.03	CHILD PSYCHIATRIC CLINIC	791	618		1,409	83	10,091	90.03
90.04	SPECIAL SURGICAL SERVICES	463	1,284	20,078	21,825	92	14,501	90.04
90.05	GENETIC SERVICES	2,513	794	18,976	22,283	113	14,478	90.05
91	Emergency	9,554	6,171	504,265	519,990	1,962	288,598	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	265	2,198	3,024	5,487	330	22,446	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)	2,707,245	268,234	15,470,565	18,446,044	31,976	6,248,214	118
	NONREIMBURSABLE COST CENTERS							

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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	
192	Physicians' Private Offices		196		196		54	192
193.01	BELOIT HEART STANDBY	1,677			1,677	14	1,673	193.01
194	GUEST CENTER		2,001	8,260	10,261	20	13,081	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	54	1,487	5,582	7,123	49	24,084	194.02
194.04	AUXILIARY	821	3,856	268	4,945	46	14,349	194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,709,797	275,774	15,484,675	18,470,246	32,105	6,301,455	202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,802,460						7
8	Laundry & Linen Service	16,498	31,827					8
9	Housekeeping	35,707		179,956				9
10	Dietary	41,826		4,105	142,559			10
11	Cafeteria	93,890		9,630		178,892		11
12	Maintenance of Personnel							12
13	Nursing Administration	24,916		2,522		4,808	235,768	13
14	Central Services & Supply	48,735	155	4,932		4,887		14
15	Pharmacy	28,104		2,844		6,244		15
16	Medical Records & Library	23,980		2,427		2,870		16
17	Social Service	6,988		707		573		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	8,931		1,351		180		22
23	PARAMDICAL ED PROGRAM XRAY	2,534		256		10,802		23
23.01	PASTORAL EDUCATION PROGRAM	2,229		276		4,354		23.01
23.02	PARAMED EDUC EMT PROGRAM	21,735		4,641		1,483	29	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	434,604	11,439	44,832	116,489	39,003	107,889	30
31	Intensive Care Unit	37,725	998	3,818	11,611	6,654	2,613	31
34.01	NEONATAL INTENSIVE CARE	51,736	655	4,868		10,096	20,549	34.01
34.02	PEDIATRIC INTENSIVE CARE	13,788		1,395	2,530	1,735	1,961	34.02
40	Subprovider - IPF	49,166	284	4,976	10,390	3,336	2,286	40
43	Nursery	28,712	529	2,760		4,518	11,114	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	145,900	4,561	14,318		11,979	19,530	50
51	Recovery Room	12,154	250	1,230		1,160	4,396	51
52	Delivery Room & Labor Room	53,009	3,208	5,365		5,821	12,781	52
53	Anesthesiology	3,498		354		895	6,908	53
54	Radiology-Diagnostic	48,865	1,326	4,945		6,566	1,587	54
55	Radiology-Therapeutic	60,228	133	6,095		1,997	3,693	55
56	Radioisotope	5,519		559		450		56
57	CT Scan	11,207		1,134		1,531	7	57
58	MRI	22,131	263	2,240		1,070	36	58
59	Cardiac Catheterization	21,101	385	2,135		1,703	299	59
60	Laboratory	74,697	258	7,560		14,489		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	2,820		285		293		63
64	Intravenous Therapy	3,858		390		422	15	64
65	Respiratory Therapy	21,469	3	2,173		4,770	15	65
66	Physical Therapy	20,846	16	2,110		2,779		66
69	Electrocardiology	41,775		4,228		2,029	1,609	69
70	Electroencephalography	20,991	5	2,124		1,215		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	6,655		673				74
76	GI LAB	17,548	578	1,776		1,212	1,761	76
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	21,751	353	2,201		1,561	2,077	90.01
90.02	ANTENATAL TEST CENTER	20,466	416	2,071		1,143	129	90.02
90.03	CHILD PSYCHIATRIC CLINIC	6,447	4	652		317		90.03
90.04	SPECIAL SURGICAL SERVICES	13,400		1,356		490	532	90.04
90.05	GENETIC SERVICES	8,284	4	838		581		90.05
91	Emergency	64,403	5,882	6,518	1,539	10,528	25,175	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	22,938	4	2,321		1,488	8,777	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)	1,723,764	31,709	171,991	142,559	178,032	235,768	118
	NONREIMBURSABLE COST CENTERS							

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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	
192	Physicians' Private Offices	2,049		207				192
193.01	BELOIT HEART STANDBY					24		193.01
194	GUEST CENTER	20,885	118	2,114		136		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	15,519		1,571		242		194.02
194.04	AUXILIARY	40,243		4,073		458		194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,802,460	31,827	179,956	142,559	178,892	235,768	202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	I&R PROGRAM COSTS	PARAMEDICA EDUCATION XRAY	
		14	15	16	17	22	23	
	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	951,120						14
15	Pharmacy	1,373	596,610					15
16	Medical Records & Library			107,778				16
17	Social Service				22,218			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					41,183		22
23	PARAMEDICAL ED PROGRAM XRAY						24,906	23
23.01	PASTORAL EDUCATION PROGRAM							23.01
23.02	PARAMED EDUC EMT PROGRAM	113	3,179					23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	60	8,499	4,904	18,923			30
31	Intensive Care Unit		2,683	1,287				31
34.01	NEONATAL INTENSIVE CARE	1	2,105	4,124	290			34.01
34.02	PEDIATRIC INTENSIVE CARE		950	407	82			34.02
40	Subprovider - IPF			454	2,761			40
43	Nursery			1,806	162			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6	5,442	6,283				50
51	Recovery Room	614	444	753				51
52	Delivery Room & Labor Room		2,551	1,938				52
53	Anesthesiology	3	7,812	1,216				53
54	Radiology-Diagnostic	757	3,345	4,784				54
55	Radiology-Therapeutic	80	41	897				55
56	Radioisotope	10,360	25	947				56
57	CT Scan	225	271	5,974				57
58	MRI	284	293	2,315				58
59	Cardiac Catheterization		4,674	2,130				59
60	Laboratory	123,915	2	7,136				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	28,208		974				63
64	Intravenous Therapy		591	3,923				64
65	Respiratory Therapy	9	45	2,999				65
66	Physical Therapy			698				66
69	Electrocardiology	8,138	382	3,050				69
70	Electroencephalography	1,173		829				70
71	Medical Supplies Charged to Patients	433,532		15,875				71
72	Impl. Dev. Charged to Patients	341,358		8,180				72
73	Drugs Charged to Patients		538,823	15,745				73
74	Renal Dialysis		16	116				74
76	GI LAB		360	767				76
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		776	1,000				90.01
90.02	ANTENATAL TEST CENTER	333		1,222				90.02
90.03	CHILD PSYCHIATRIC CLINIC	4		29				90.03
90.04	SPECIAL SURGICAL SERVICES		1,143	284				90.04
90.05	GENETIC SERVICES	24		34				90.05
91	Emergency	45	12,064	4,630				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	469	38	68				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)	951,084	596,554	107,778	22,218			118
	NONREIMBURSABLE COST CENTERS							

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	I&R PROGRAM COSTS 22	PARAMEDICA EDUCATION XRAY 23	
192	Physicians' Private Offices	15						192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER							194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	21	56					194.02
194.04	AUXILIARY							194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments					41,183	24,906	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	951,120	596,610	107,778	22,218	41,183	24,906	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	23.01	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	10,907					23.01
23.02	PARAMED EDUC EMT PROGRAM		227,571				23.02
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics			3,208,044		3,208,044	30
31	Intensive Care Unit			463,244		463,244	31
34.01	NEONATAL INTENSIVE CARE			602,971		602,971	34.01
34.02	PEDIATRIC INTENSIVE CARE			84,284		84,284	34.02
40	Subprovider - IPF			202,329		202,329	40
43	Nursery			264,858		264,858	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room			2,191,017		2,191,017	50
51	Recovery Room			65,458		65,458	51
52	Delivery Room & Labor Room			463,382		463,382	52
53	Anesthesiology			143,656		143,656	53
54	Radiology-Diagnostic			1,258,511		1,258,511	54
55	Radiology-Therapeutic			1,329,511		1,329,511	55
56	Radioisotope			49,641		49,641	56
57	CT Scan			205,951		205,951	57
58	MRI			185,794		185,794	58
59	Cardiac Catheterization			431,623		431,623	59
60	Laboratory			1,148,800		1,148,800	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.			77,035		77,035	63
64	Intravenous Therapy			23,222		23,222	64
65	Respiratory Therapy			376,570		376,570	65
66	Physical Therapy			103,202		103,202	66
69	Electrocardiology			144,898		144,898	69
70	Electroencephalography			198,590		198,590	70
71	Medical Supplies Charged to Patients			977,347		977,347	71
72	Impl. Dev. Charged to Patients			765,244		765,244	72
73	Drugs Charged to Patients			1,014,925		1,014,925	73
74	Renal Dialysis			32,505		32,505	74
76	GI LAB			401,657		401,657	76
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			223,222		223,222	90.01
90.02	ANTENATAL TEST CENTER			237,887		237,887	90.02
90.03	CHILD PSYCHIATRIC CLINIC			19,036		19,036	90.03
90.04	SPECIAL SURGICAL SERVICES			53,623		53,623	90.04
90.05	GENETIC SERVICES			46,639		46,639	90.05
91	Emergency			941,334		941,334	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services			64,366		64,366	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)			18,000,376		18,000,376	118
	NONREIMBURSABLE COST CENTERS						

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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		
		23.01	23.02	24	25	26		
192	Physicians' Private Offices			2,521		2,521		192
193.01	BELOIT HEART STANDBY			3,388		3,388		193.01
194	GUEST CENTER			46,615		46,615		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES			48,665		48,665		194.02
194.04	AUXILIARY			64,114		64,114		194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments	10,907	227,571	304,567		304,567		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,907	227,571	18,470,246		18,470,246		202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	734,802						1
2	Cap Rel Costs-Mvble Equip		15,313,839					2
4	Employee Benefits Department	11,888	27,338	100,281,826				4
5	Administrative & General	174,581	4,146,755	2,694,489	-45,460,106	201,718,947		5
6	Maintenance & Repairs							6
7	Operation of Plant	81,039	1,348,424	2,850,941		12,877,654	460,164	7
8	Laundry & Linen Service	4,212	5,243	154,228		268,829	4,212	8
9	Housekeeping	9,116	38,260	2,013,986		3,182,852	9,116	9
10	Dietary	10,355	20,897	779,822		2,227,713	10,678	10
11	Cafeteria	24,292	49,020	1,628,894		390,325	23,970	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,361	24,160	3,976,631		5,153,184	6,361	13
14	Central Services & Supply	12,442	411,736	1,343,639		2,916,023	12,442	14
15	Pharmacy	7,175	357,917	4,215,958		5,911,349	7,175	15
16	Medical Records & Library	6,122	7,499	1,197,587		2,137,907	6,122	16
17	Social Service	1,784		343,560		412,043	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	3,409		469,557		933,628	2,280	22
23	PARAMDICAL ED PROGRAM XRAY	647	90	179,443		207,081	647	23
23.01	PASTORAL EDUCATION PROGRAM	696		72,211		114,511	569	23.01
23.02	PARAMED EDUC EMT PROGRAM	11,708	143,916	718,324		1,160,252	5,549	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,094	1,426,951	20,897,404		28,303,737	110,953	30
31	Intensive Care Unit	9,631	232,283	3,522,830		4,910,314	9,631	31
34.01	NEONATAL INTENSIVE CARE	12,279	221,083	6,661,158		8,650,738	13,208	34.01
34.02	PEDIATRIC INTENSIVE CARE	3,520	13,201	1,145,245		1,446,297	3,520	34.02
40	Subprovider - IPF	12,552	53,858	1,547,959		2,042,252	12,552	40
43	Nursery	6,962	113,224	2,392,668		3,034,885	7,330	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,120	1,532,221	7,401,090		12,976,578	37,248	50
51	Recovery Room	3,103	7,407	898,437		1,136,866	3,103	51
52	Delivery Room & Labor Room	13,533	190,399	3,616,849		5,610,813	13,533	52
53	Anesthesiology	893	91,180	451,317		898,685	893	53
54	Radiology-Diagnostic	12,475	1,001,234	3,164,610		5,241,578	12,475	54
55	Radiology-Therapeutic	15,376	1,143,412	1,141,641		2,892,747	15,376	55
56	Radioisotope	1,409	1,114	261,764		955,072	1,409	56
57	CT Scan	2,861	140,282	837,222		1,333,733	2,861	57
58	MRI	5,650	121,240	609,869		1,012,267	5,650	58
59	Cardiac Catheterization	5,387	337,105	1,008,756		1,792,155	5,387	59
60	Laboratory	19,070	585,460	5,621,490		9,333,656	19,070	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	720	2,689	142,798		1,304,930	720	63
64	Intravenous Therapy	985	1,967	264,223		352,037	985	64
65	Respiratory Therapy	5,481	199,385	2,342,346		3,719,157	5,481	65
66	Physical Therapy	5,322	972	1,671,857		2,150,697	5,322	66
69	Electrocardiology	10,665	20,428	1,051,885		1,760,657	10,665	69
70	Electroencephalography	5,359	131,603	631,589		1,079,031	5,359	70
71	Medical Supplies Charged to Patients					16,900,040		71
72	Impl. Dev. Charged to Patients					13,307,278		72
73	Drugs Charged to Patients					14,736,620		73
74	Renal Dialysis	1,699	1,593			729,736	1,699	74
76	GI LAB	4,480	286,695	590,750		1,134,450	4,480	76
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	152,042	681,783		1,039,505	5,553	90.01
90.02	ANTENATAL TEST CENTER	5,225	169,287	620,781		1,127,173	5,225	90.02
90.03	CHILD PSYCHIATRIC CLINIC	1,646		259,867		323,029	1,646	90.03
90.04	SPECIAL SURGICAL SERVICES	3,421	19,856	287,327		464,198	3,421	90.04
90.05	GENETIC SERVICES	2,115	18,767	353,897		463,451	2,115	90.05
91	Emergency	16,442	498,701	6,131,736		9,238,379	16,442	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	5,856	2,991	1,030,144		718,537	5,856	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)	714,711	15,299,885	99,880,562	-45,460,106	200,014,629	440,073	118

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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	
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	523				1,736	523	192
193.01	BELOIT HEART STANDBY			42,762		53,556		193.01
194	GUEST CENTER	5,332	8,169	63,421		418,737	5,332	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	3,962	5,520	152,748		770,953	3,962	194.02
194.04	AUXILIARY	10,274	265	142,333		459,336	10,274	194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	275,774	15,484,675	14,901,673		45,460,106	15,779,814	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.375304	1.011156	0.148598		0.225364	34.291718	203
204	Cost to be allocated (Per Wkst. B, Part II)			32,105		6,301,455	1,802,460	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000320		0.031239	3.916995	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	761,985						8
9	Housekeeping		453,966					9
10	Dietary		10,355	200,057				10
11	Cafeteria		24,292		134,273			11
12	Maintenance of Personnel							12
13	Nursing Administration		6,361		3,609	290,043		13
14	Central Services & Supply	3,706	12,442		3,668		37,077,217	14
15	Pharmacy		7,175		4,687		53,515	15
16	Medical Records & Library		6,122		2,154			16
17	Social Service		1,784		430			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		3,409		135			22
23	PARAMDICAL ED PROGRAM XRAY		647		8,108			23
23.01	PASTORAL EDUCATION PROGRAM		696		3,268			23.01
23.02	PARAMED EDUC EMT PROGRAM		11,708		1,113	36	4,398	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	273,848	113,094	163,471	29,274	132,727	2,343	30
31	Intensive Care Unit	23,896	9,631	16,294	4,994	3,214		31
34.01	NEONATAL INTENSIVE CARE	15,691	12,279		7,578	25,280	34	34.01
34.02	PEDIATRIC INTENSIVE CARE		3,520	3,551	1,302	2,412		34.02
40	Subprovider - IPF	6,803	12,552	14,581	2,504	2,812		40
43	Nursery	12,658	6,962		3,391	13,672		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	109,202	36,120		8,991	24,026	244	50
51	Recovery Room	5,993	3,103		871	5,408	23,927	51
52	Delivery Room & Labor Room	76,805	13,533		4,369	15,723		52
53	Anesthesiology		893		672	8,498	124	53
54	Radiology-Diagnostic	31,747	12,475		4,928	1,952	29,496	54
55	Radiology-Therapeutic	3,181	15,376		1,499	4,543	3,103	55
56	Radioisotope	9	1,409		338		403,863	56
57	CT Scan		2,861		1,149	8	8,755	57
58	MRI	6,291	5,650		803	44	11,058	58
59	Cardiac Catheterization	9,222	5,387		1,278	368		59
60	Laboratory	6,165	19,070		10,875		4,830,599	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		720		220		1,099,633	63
64	Intravenous Therapy		985		317	19		64
65	Respiratory Therapy	64	5,481		3,580	19	349	65
66	Physical Therapy	377	5,322		2,086			66
69	Electrocardiology		10,665		1,523	1,980	317,246	69
70	Electroencephalography	113	5,359		912		45,725	70
71	Medical Supplies Charged to Patients						16,900,042	71
72	Impl. Dev. Charged to Patients						13,307,278	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		1,699					74
76	GI LAB	13,828	4,480		910	2,166		76
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	8,450	5,553		1,172	2,555		90.01
90.02	ANTENATAL TEST CENTER	9,970	5,225		858	159	12,975	90.02
90.03	CHILD PSYCHIATRIC CLINIC	107	1,646		238		143	90.03
90.04	SPECIAL SURGICAL SERVICES		3,421		368	655		90.04
90.05	GENETIC SERVICES	104	2,115		436		924	90.05
91	Emergency	140,823	16,442	2,160	7,902	30,970	1,764	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	98	5,856		1,117	10,797	18,266	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)	759,151	433,875	200,057	133,627	290,043	37,075,804	118

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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	
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		523				602	192
193.01	BELOIT HEART STANDBY				18			193.01
194	GUEST CENTER	2,834	5,332		102			194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES		3,962		182		811	194.02
194.04	AUXILIARY		10,274		344			194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	473,850	4,212,755	3,192,019	1,525,689	6,632,693	4,159,291	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.621863	9.279891	15.955548	11.362590	22.867964	0.112179	203
204	Cost to be allocated (Per Wkst. B, Part II)	31,827	179,956	142,559	178,892	235,768	951,120	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.041769	0.396409	0.712592	1.332301	0.812873	0.025652	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	I&R PROGRAM COSTS ASSIGNED TIME	PARAMEDICA EDUCATION XRAY ASSIGNED TIME	ASSIGNED TIME	
		15	16	17	22	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							14
15	Pharmacy	16,317,096						15
16	Medical Records & Library		1,173,029,826					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				100			22
23	PARAMEDICAL ED PROGRAM XRAY					100		23
23.01	PASTORAL EDUCATION PROGRAM						32,516	23.01
23.02	PARAMED EDUC EMT PROGRAM	86,934						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	232,449	53,307,802	6,661	100		20,522	30
31	Intensive Care Unit	73,383	13,984,366				2,267	31
34.01	NEONATAL INTENSIVE CARE	57,576	44,831,354	102			5,935	34.01
34.02	PEDIATRIC INTENSIVE CARE	25,975	4,422,519	29			647	34.02
40	Subprovider - IPF	10	4,937,506	972			1,865	40
43	Nursery		19,626,636	57			1,280	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	148,847	68,288,775					50
51	Recovery Room	12,152	8,183,482					51
52	Delivery Room & Labor Room	69,759	21,061,452					52
53	Anesthesiology	213,668	13,215,694					53
54	Radiology-Diagnostic	91,475	51,996,685			100		54
55	Radiology-Therapeutic	1,108	9,746,946					55
56	Radioisotope	672	10,291,947					56
57	CT Scan	7,410	64,929,981					57
58	MRI	8,008	25,166,292					58
59	Cardiac Catheterization	127,844	23,157,276					59
60	Laboratory	66	77,569,574					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		10,589,149					63
64	Intravenous Therapy	16,152	42,642,571					64
65	Respiratory Therapy	1,239	32,601,104					65
66	Physical Therapy		7,587,060					66
69	Electrocardiology	10,456	33,146,807					69
70	Electroencephalography		9,006,043					70
71	Medical Supplies Charged to Patients		174,082,214					71
72	Impl. Dev. Charged to Patients		88,911,599					72
73	Drugs Charged to Patients	14,736,620	171,144,321					73
74	Renal Dialysis	428	1,265,134					74
76	GI LAB	9,839	8,338,277					76
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	21,232	10,873,915					90.01
90.02	ANTENATAL TEST CENTER		13,279,275					90.02
90.03	CHILD PSYCHIATRIC CLINIC		312,224					90.03
90.04	SPECIAL SURGICAL SERVICES	31,274	3,090,732					90.04
90.05	GENETIC SERVICES		368,291					90.05
91	Emergency	329,958	50,330,893					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,038	741,930					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)	16,315,572	1,173,029,826	7,821	100	100	32,516	118

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	I&R PROGRAM COSTS ASSIGNED TIME	PARAMEDICA EDUCATION XRAY ASSIGNED TIME	ASSIGNED TIME	
		15	16	17	22	23	23.01	
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER							194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	1,524						194.02
194.04	AUXILIARY							194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	7,615,439	2,910,934	587,520	1,255,388	374,069	203,422	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.466715	0.002482	75.120829	12,553.880000	3,740.690000	6.256059	203
204	Cost to be allocated (Per Wkst. B, Part II)	596,610	107,778	22,218	41,183	24,906	10,907	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.036563	0.000092	2.840813	411.830000	249.060000	0.335435	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT TIME SPENT					
		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						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	640					23.02
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17					30
31	Intensive Care Unit						31
34.01	NEONATAL INTENSIVE CARE	34					34.01
34.02	PEDIATRIC INTENSIVE CARE						34.02
40	Subprovider - IPF						40
43	Nursery						43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	89					50
51	Recovery Room						51
52	Delivery Room & Labor Room	17					52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.						63
64	Intravenous Therapy						64
65	Respiratory Therapy	13					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
76.97	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
90.04	SPECIAL SURGICAL SERVICES						90.04
90.05	GENETIC SERVICES						90.05
91	Emergency	470					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
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT TIME SPENT					
		23.02					
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	640					118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices						192
193.01	BELOIT HEART STANDBY						193.01
194	GUEST CENTER						194
194.01	OTHER NONREIMBURSEABLE COST CENTER						194.01
194.02	COMMUNITY SERVICES						194.02
194.04	AUXILIARY						194.04
194.08	DIALYSIS RENTED SPACE						194.08
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	1,775,201					202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,773.751563					203
204	Cost to be allocated (Per Wkst. B, Part II)	227,571					204
205	Unit Cost Multiplier (Wkst. B, Part II)	355.579688					205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)						206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)						207

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	46,599,929		46,599,929		46,599,929	30
31	Intensive Care Unit	6,924,784		6,924,784		6,924,784	31
34.01	NEONATAL INTENSIVE CARE	12,118,389		12,118,389		12,118,389	34.01
34.02	PEDIATRIC INTENSIVE CARE	2,081,549		2,081,549		2,081,549	34.02
40	Subprovider - IPF	3,475,994		3,475,994		3,475,994	40
43	Nursery	4,454,861		4,454,861		4,454,861	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	18,718,869		18,718,869	43,677	18,762,546	50
51	Recovery Room	1,694,239		1,694,239		1,694,239	51
52	Delivery Room & Labor Room	8,053,888		8,053,888		8,053,888	52
53	Anesthesiology	1,474,631		1,474,631		1,474,631	53
54	Radiology-Diagnostic	7,635,899		7,635,899		7,635,899	54
55	Radiology-Therapeutic	4,362,582		4,362,582		4,362,582	55
56	Radioisotope	1,306,714		1,306,714		1,306,714	56
57	CT Scan	1,937,802		1,937,802		1,937,802	57
58	MRI	1,568,057		1,568,057		1,568,057	58
59	Cardiac Catheterization	2,576,576		2,576,576		2,576,576	59
60	Laboratory	13,129,890		13,129,890		13,129,890	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	1,782,524		1,782,524		1,782,524	63
64	Intravenous Therapy	591,704		591,704		591,704	64
65	Respiratory Therapy	4,954,881		4,954,881		4,954,881	65
66	Physical Therapy	2,910,043		2,910,043		2,910,043	66
69	Electrocardiology	2,807,459		2,807,459		2,807,459	69
70	Electroencephalography	1,593,621		1,593,621		1,593,621	70
71	Medical Supplies Charged to Patients	23,036,084		23,036,084		23,036,084	71
72	Impl. Dev. Charged to Patients	18,019,735		18,019,735		18,019,735	72
73	Drugs Charged to Patients	25,360,312		25,360,312		25,360,312	73
74	Renal Dialysis	971,561		971,561		971,561	74
76	GI LAB	1,679,074		1,679,074		1,679,074	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	1,629,623		1,629,623		1,629,623	90.01
90.02	ANTENATAL TEST CENTER	1,662,858		1,662,858		1,662,858	90.02
90.03	CHILD PSYCHIATRIC CLINIC	471,109		471,109		471,109	90.03
90.04	SPECIAL SURGICAL SERVICES	759,298		759,298		759,298	90.04
90.05	GENETIC SERVICES	666,087		666,087		666,087	90.05
91	Emergency	14,539,603		14,539,603	813	14,540,416	91
92	Observation Beds (Non-Distinct Part)	7,192,520		7,192,520		7,192,520	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,399,656		1,399,656		1,399,656	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)	250,142,405		250,142,405	44,490	250,186,895	200
201	Less Observation Beds	7,192,520		7,192,520		7,192,520	201
202	Total (line 200 minus line 201)	242,949,885		242,949,885		242,994,375	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	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	43,999,186		43,999,186				30
31	Intensive Care Unit	13,845,972		13,845,972				31
34.01	NEONATAL INTENSIVE CARE	40,800,679		40,800,679				34.01
34.02	PEDIATRIC INTENSIVE CARE	3,800,735		3,800,735				34.02
40	Subprovider - IPF	5,136,537		5,136,537				40
43	Nursery	26,470,310		26,470,310				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,921,262	35,059,823	65,981,085	0.283701	0.283701	0.284362	50
51	Recovery Room	3,478,985	4,133,187	7,612,172	0.222570	0.222570	0.222570	51
52	Delivery Room & Labor Room	22,607,731	3,646,015	26,253,746	0.306771	0.306771	0.306771	52
53	Anesthesiology	6,152,955	6,775,934	12,928,889	0.114057	0.114057	0.114057	53
54	Radiology-Diagnostic	24,223,501	27,998,538	52,222,039	0.146220	0.146220	0.146220	54
55	Radiology-Therapeutic	339,672	12,253,580	12,593,252	0.346422	0.346422	0.346422	55
56	Radioisotope	1,960,133	9,498,452	11,458,585	0.114038	0.114038	0.114038	56
57	CT Scan	22,362,827	45,627,336	67,990,163	0.028501	0.028501	0.028501	57
58	MRI	5,288,682	20,739,335	26,028,017	0.060245	0.060245	0.060245	58
59	Cardiac Catheterization	9,705,262	11,674,357	21,379,619	0.120516	0.120516	0.120516	59
60	Laboratory	54,137,954	35,969,380	90,107,334	0.145714	0.145714	0.145714	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	6,486,050	2,085,631	8,571,681	0.207955	0.207955	0.207955	63
64	Intravenous Therapy	5,007,171	34,130,840	39,138,011	0.015118	0.015118	0.015118	64
65	Respiratory Therapy	28,927,429	2,528,856	31,456,285	0.157516	0.157516	0.157516	65
66	Physical Therapy	6,321,261	3,082,355	9,403,616	0.309460	0.309460	0.309460	66
69	Electrocardiology	11,754,127	20,993,205	32,747,332	0.085731	0.085731	0.085731	69
70	Electroencephalography	1,223,551	8,967,242	10,190,793	0.156379	0.156379	0.156379	70
71	Medical Supplies Charged to Patients	121,464,834	57,854,461	179,319,295	0.128464	0.128464	0.128464	71
72	Impl. Dev. Charged to Patients	47,932,598	27,858,320	75,790,918	0.237756	0.237756	0.237756	72
73	Drugs Charged to Patients	71,335,926	90,583,322	161,919,248	0.156623	0.156623	0.156623	73
74	Renal Dialysis	1,117,665	87,060	1,204,725	0.806459	0.806459	0.806459	74
76	GI LAB	3,631,385	8,945,318	12,576,703	0.133507	0.133507	0.133507	76
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	31,259	8,519,865	8,551,124	0.190574	0.190574	0.190574	90.01
90.02	ANTENATAL TEST CENTER	438,801	15,337,334	15,776,135	0.105403	0.105403	0.105403	90.02
90.03	CHILD PSYCHIATRIC CLINIC		211,000	211,000	2.232744	2.232744	2.232744	90.03
90.04	SPECIAL SURGICAL SERVICES	12,079	3,047,869	3,059,948	0.248141	0.248141	0.248141	90.04
90.05	GENETIC SERVICES	1,568	435,095	436,663	1.525403	1.525403	1.525403	90.05
91	Emergency	13,095,740	38,167,217	51,262,957	0.283628	0.283628	0.283644	91
92	Observation Beds (Non-Distinct Part)	1,215,237	9,503,146	10,718,383	0.671045	0.671045	0.671045	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	14,967	676,087	691,054	2.025393	2.025393	2.025393	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)	635,244,031	546,390,160	1,181,634,191				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	635,244,031	546,390,160	1,181,634,191				202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (B Part 1 col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	47,855,317		47,855,317		47,855,317	30
31	Intensive Care Unit	6,924,784		6,924,784		6,924,784	31
34.01	NEONATAL INTENSIVE CARE	12,118,389		12,118,389		12,118,389	34.01
34.02	PEDIATRIC INTENSIVE CARE	2,081,549		2,081,549		2,081,549	34.02
40	Subprovider - IPF	3,475,994		3,475,994		3,475,994	40
43	Nursery	4,454,861		4,454,861		4,454,861	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	18,718,869		18,718,869		18,718,869	50
51	Recovery Room	1,694,239		1,694,239		1,694,239	51
52	Delivery Room & Labor Room	8,053,888		8,053,888		8,053,888	52
53	Anesthesiology	1,474,631		1,474,631		1,474,631	53
54	Radiology-Diagnostic	7,635,899		7,635,899		7,635,899	54
55	Radiology-Therapeutic	4,362,582		4,362,582		4,362,582	55
56	Radioisotope	1,306,714		1,306,714		1,306,714	56
57	CT Scan	1,937,802		1,937,802		1,937,802	57
58	MRI	1,568,057		1,568,057		1,568,057	58
59	Cardiac Catheterization	2,576,576		2,576,576		2,576,576	59
60	Laboratory	13,129,890		13,129,890		13,129,890	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	1,782,524		1,782,524		1,782,524	63
64	Intravenous Therapy	591,704		591,704		591,704	64
65	Respiratory Therapy	4,954,881		4,954,881		4,954,881	65
66	Physical Therapy	2,910,043		2,910,043		2,910,043	66
69	Electrocardiology	2,807,459		2,807,459		2,807,459	69
70	Electroencephalography	1,593,621		1,593,621		1,593,621	70
71	Medical Supplies Charged to Patients	23,036,084		23,036,084		23,036,084	71
72	Impl. Dev. Charged to Patients	18,019,735		18,019,735		18,019,735	72
73	Drugs Charged to Patients	25,360,312		25,360,312		25,360,312	73
74	Renal Dialysis	971,561		971,561		971,561	74
76	GI LAB	1,679,074		1,679,074		1,679,074	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	1,629,623		1,629,623		1,629,623	90.01
90.02	ANTENATAL TEST CENTER	1,662,858		1,662,858		1,662,858	90.02
90.03	CHILD PSYCHIATRIC CLINIC	471,109		471,109		471,109	90.03
90.04	SPECIAL SURGICAL SERVICES	759,298		759,298		759,298	90.04
90.05	GENETIC SERVICES	666,087		666,087		666,087	90.05
91	Emergency	14,539,603		14,539,603		14,539,603	91
92	Observation Beds (Non-Distinct Part)	7,386,266		7,386,266		7,386,266	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,399,656		1,399,656		1,399,656	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)	251,591,539		251,591,539		251,591,539	200
201	Less Observation Beds	7,386,266		7,386,266		7,386,266	201
202	Total (line 200 minus line 201)	244,205,273		244,205,273		244,205,273	202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**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	9	10	11	
	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
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
64	Intravenous Therapy							64
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
76.97	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
90.04	SPECIAL SURGICAL SERVICES							90.04
90.05	GENETIC SERVICES							90.05
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
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	18,718,869	2,191,017	16,527,852		50
51	Recovery Room	1,694,239	65,458	1,628,781		51
52	Delivery Room & Labor Room	8,053,888	463,382	7,590,506		52
53	Anesthesiology	1,474,631	143,656	1,330,975		53
54	Radiology-Diagnostic	7,635,899	1,258,511	6,377,388		54
55	Radiology-Therapeutic	4,362,582	1,329,511	3,033,071		55
56	Radioisotope	1,306,714	49,641	1,257,073		56
57	CT Scan	1,937,802	205,951	1,731,851		57
58	MRI	1,568,057	185,794	1,382,263		58
59	Cardiac Catheterization	2,576,576	431,623	2,144,953		59
60	Laboratory	13,129,890	1,148,800	11,981,090		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Trans.	1,782,524	77,035	1,705,489		63
64	Intravenous Therapy	591,704	23,222	568,482		64
65	Respiratory Therapy	4,954,881	376,570	4,578,311		65
66	Physical Therapy	2,910,043	103,202	2,806,841		66
69	Electrocardiology	2,807,459	144,898	2,662,561		69
70	Electroencephalography	1,593,621	198,590	1,395,031		70
71	Medical Supplies Charged to Patients	23,036,084	977,347	22,058,737		71
72	Impl. Dev. Charged to Patients	18,019,735	765,244	17,254,491		72
73	Drugs Charged to Patients	25,360,312	1,014,925	24,345,387		73
74	Renal Dialysis	971,561	32,505	939,056		74
76	GI LAB	1,679,074	401,657	1,277,417		76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	PAIN CENTER	1,629,623	223,222	1,406,401		90.01
90.02	ANTENATAL TEST CENTER	1,662,858	237,887	1,424,971		90.02
90.03	CHILD PSYCHIATRIC CLINIC	471,109	19,036	452,073		90.03
90.04	SPECIAL SURGICAL SERVICES	759,298	53,623	705,675		90.04
90.05	GENETIC SERVICES	666,087	46,639	619,448		90.05
91	Emergency	14,539,603	941,334	13,598,269		91
92	Observation Beds (Non-Distinct Part)	7,386,266	495,146	6,891,120		92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services	1,399,656	64,366	1,335,290		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	174,680,645	13,669,792	161,010,853		200
201	Less Observation Beds	7,386,266	495,146	6,891,120		201
202	Total	167,294,379	13,174,646	154,119,733		202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		18,718,869			50
51	Recovery Room		1,694,239			51
52	Delivery Room & Labor Room		8,053,888			52
53	Anesthesiology		1,474,631			53
54	Radiology-Diagnostic		7,635,899			54
55	Radiology-Therapeutic		4,362,582			55
56	Radioisotope		1,306,714			56
57	CT Scan		1,937,802			57
58	MRI		1,568,057			58
59	Cardiac Catheterization		2,576,576			59
60	Laboratory		13,129,890			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Trans.		1,782,524			63
64	Intravenous Therapy		591,704			64
65	Respiratory Therapy		4,954,881			65
66	Physical Therapy		2,910,043			66
69	Electrocardiology		2,807,459			69
70	Electroencephalography		1,593,621			70
71	Medical Supplies Charged to Patients		23,036,084			71
72	Impl. Dev. Charged to Patients		18,019,735			72
73	Drugs Charged to Patients		25,360,312			73
74	Renal Dialysis		971,561			74
76	GI LAB		1,679,074			76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	PAIN CENTER		1,629,623			90.01
90.02	ANTENATAL TEST CENTER		1,662,858			90.02
90.03	CHILD PSYCHIATRIC CLINIC		471,109			90.03
90.04	SPECIAL SURGICAL SERVICES		759,298			90.04
90.05	GENETIC SERVICES		666,087			90.05
91	Emergency		14,539,603			91
92	Observation Beds (Non-Distinct Part)		7,386,266	10,718,383	0.689121	92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services		1,399,656			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		174,680,645	10,718,383		200
201	Less Observation Beds		7,386,266	10,718,383		201
202	Total		167,294,379			202

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,208,044		3,208,044	43,435	73.86	13,271	980,196	30
31	Intensive Care Unit	463,244		463,244	4,033	114.86	2,000	229,720	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	602,971		602,971	14,352	42.01			34.01
34.02	PEDIATRIC INTENSIVE CARE	84,284		84,284	879	95.89			34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	202,329		202,329	3,609	56.06	963	53,986	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	264,858		264,858	3,557	74.46			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,825,730		4,825,730	69,865		16,234	1,263,902	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0239

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,191,017	65,981,085	0.033207	8,959,970	297,534	50
51	Recovery Room	65,458	7,612,172	0.008599	1,046,793	9,001	51
52	Delivery Room & Labor Room	463,382	26,253,746	0.017650	175,061	3,090	52
53	Anesthesiology	143,656	12,928,889	0.011111	1,580,670	17,563	53
54	Radiology-Diagnostic	1,258,511	52,222,039	0.024099	8,103,614	195,289	54
55	Radiology-Therapeutic	1,329,511	12,593,252	0.105573	125,261	13,224	55
56	Radioisotope	49,641	11,458,585	0.004332	1,007,757	4,366	56
57	CT Scan	205,951	67,990,163	0.003029	8,036,241	24,342	57
58	MRI	185,794	26,028,017	0.007138	1,851,963	13,219	58
59	Cardiac Catheterization	431,623	21,379,619	0.020189	4,192,134	84,635	59
60	Laboratory	1,148,800	90,107,334	0.012749	16,988,521	216,587	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	77,035	8,571,681	0.008987	1,700,977	15,287	63
64	Intravenous Therapy	23,222	39,138,011	0.000593	1,780,898	1,056	64
65	Respiratory Therapy	376,570	31,456,285	0.011971	5,636,803	67,478	65
66	Physical Therapy	103,202	9,403,616	0.010975	2,550,931	27,996	66
69	Electrocardiology	144,898	32,747,332	0.004425	4,856,764	21,491	69
70	Electroencephalography	198,590	10,190,793	0.019487	263,779	5,140	70
71	Medical Supplies Charged to Pat	977,347	179,319,295	0.005450	33,756,315	183,972	71
72	Impl. Dev. Charged to Patients	765,244	75,790,918	0.010097	14,708,845	148,515	72
73	Drugs Charged to Patients	1,014,925	161,919,248	0.006268	23,393,068	146,628	73
74	Renal Dialysis	32,505	1,204,725	0.026981	581,193	15,681	74
76	GI LAB	401,657	12,576,703	0.031937	1,544,075	49,313	76
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	223,222	8,551,124	0.026104	23,471	613	90.01
90.02	ANTENATAL TEST CENTER	237,887	15,776,135	0.015079	19,928	300	90.02
90.03	CHILD PSYCHIATRIC CLINIC	19,036	211,000	0.090218			90.03
90.04	SPECIAL SURGICAL SERVICES	53,623	3,059,948	0.017524	3,245	57	90.04
90.05	GENETIC SERVICES	46,639	436,663	0.106808	224	24	90.05
91	Emergency	941,334	51,262,957	0.018363	4,987,760	91,590	91
92	Observation Beds (Non-Distinct	495,147	10,718,383	0.046196	478,812	22,119	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	13,605,427	1,046,889,718		148,355,073	1,676,110	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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.)	
		1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				175,540			175,540	30
31	Intensive Care Unit				14,182			14,182	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE				131,438			131,438	34.01
34.02	PEDIATRIC INTENSIVE CARE				4,048			4,048	34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF				11,668			11,668	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery				8,008			8,008	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)				344,884			344,884	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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)	43,435	4.04	13,271	53,615	30
31	Intensive Care Unit	4,033	3.52	2,000	7,040	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	14,352	9.16			34.01
34.02	PEDIATRIC INTENSIVE CARE	879	4.61			34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	3,609	3.23	963	3,110	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,557	2.25			43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	69,865		16,234	63,765	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					246,864		246,864	246,864	50
51	Recovery Room									51
52	Delivery Room & Labor Room					47,154		47,154	47,154	52
53	Anesthesiology									53
54	Radiology-Diagnostic					374,069		374,069	374,069	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
64	Intravenous Therapy									64
65	Respiratory Therapy					36,059		36,059	36,059	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
76.97	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
90.04	SPECIAL SURGICAL SERVICES									90.04
90.05	GENETIC SERVICES									90.05
91	Emergency					1,303,662		1,303,662	1,303,662	91
92	Observation Beds (Non-Distinct					27,094		27,094	27,094	92
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)					2,034,902		2,034,902	2,034,902	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	65,981,085	0.003741	0.003741	8,959,970	33,519	6,551,088	24,508	50
51	Recovery Room	7,612,172			1,046,793		551,453		51
52	Delivery Room & Labor Room	26,253,746	0.001796	0.001796	175,061	314	44,440	80	52
53	Anesthesiology	12,928,889			1,580,670		1,255,698		53
54	Radiology-Diagnostic	52,222,039	0.007163	0.007163	8,103,614	58,046	5,959,840	42,690	54
55	Radiology-Therapeutic	12,593,252			125,261		3,079,513		55
56	Radioisotope	11,458,585			1,007,757		3,325,543		56
57	CT Scan	67,990,163			8,036,241		10,734,501		57
58	MRI	26,028,017			1,851,963		4,418,010		58
59	Cardiac Catheterization	21,379,619			4,192,134		3,966,717		59
60	Laboratory	90,107,334			16,988,521		5,290,705		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	8,571,681			1,700,977		409,957		63
64	Intravenous Therapy	39,138,011			1,780,898		5,784,465		64
65	Respiratory Therapy	31,456,285	0.001146	0.001146	5,636,803	6,460	558,592	640	65
66	Physical Therapy	9,403,616			2,550,931		183,159		66
69	Electrocardiology	32,747,332			4,856,764		6,463,839		69
70	Electroencephalography	10,190,793			263,779		1,690,373		70
71	Medical Supplies Charged to Pat	179,319,295			33,756,315		14,351,279		71
72	Impl. Dev. Charged to Patients	75,790,918			14,708,845		7,586,509		72
73	Drugs Charged to Patients	161,919,248			23,393,068		27,828,040		73
74	Renal Dialysis	1,204,725			581,193		50,734		74
76	GI LAB	12,576,703			1,544,075		1,739,381		76
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	8,551,124			23,471		1,931,921		90.01
90.02	ANTENATAL TEST CENTER	15,776,135			19,928		210,509		90.02
90.03	CHILD PSYCHIATRIC CLINIC	211,000							90.03
90.04	SPECIAL SURGICAL SERVICES	3,059,948			3,245		1,238,448		90.04
90.05	GENETIC SERVICES	436,663			224		14,668		90.05
91	Emergency	51,262,957	0.025431	0.025431	4,987,760	126,844	5,748,576	146,192	91
92	Observation Beds (Non-Distinct	10,718,383	0.002528	0.002528	478,812	1,210	1,798,210	4,546	92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	1,046,889,718			148,355,073	226,393	122,766,168	218,656	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	0.283701	6,551,088			1,858,550			50
51	Recovery Room	0.222570	551,453			122,737			51
52	Delivery Room & Labor Room	0.306771	44,440			13,633			52
53	Anesthesiology	0.114057	1,255,698			143,221			53
54	Radiology-Diagnostic	0.146220	5,959,840			871,448			54
55	Radiology-Therapeutic	0.346422	3,079,513			1,066,811			55
56	Radioisotope	0.114038	3,325,543			379,238			56
57	CT Scan	0.028501	10,734,501			305,944			57
58	MRI	0.060245	4,418,010			266,163			58
59	Cardiac Catheterization	0.120516	3,966,717			478,053			59
60	Laboratory	0.145714	5,290,705	13,435		770,930	1,958		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.207955	409,957			85,253			63
64	Intravenous Therapy	0.015118	5,784,465			87,450			64
65	Respiratory Therapy	0.157516	558,592			87,987			65
66	Physical Therapy	0.309460	183,159			56,680			66
69	Electrocardiology	0.085731	6,463,839			554,151			69
70	Electroencephalography	0.156379	1,690,373			264,339			70
71	Medical Supplies Charged to Pat	0.128464	14,351,279			1,843,623			71
72	Impl. Dev. Charged to Patients	0.237756	7,586,509			1,803,738			72
73	Drugs Charged to Patients	0.156623	27,828,040		102,932	4,358,511		16,122	73
74	Renal Dialysis	0.806459	50,734			40,915			74
76	GI LAB	0.133507	1,739,381			232,220			76
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	0.190574	1,931,921			368,174			90.01
90.02	ANTENATAL TEST CENTER	0.105403	210,509			22,188			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.232744							90.03
90.04	SPECIAL SURGICAL SERVICES	0.248141	1,238,448			307,310			90.04
90.05	GENETIC SERVICES	1.525403	14,668			22,375			90.05
91	Emergency	0.283628	5,748,576			1,630,457			91
92	Observation Beds (Non-Distinct	0.671045	1,798,210			1,206,680			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	2.025393							95
200	Subtotal (see instructions)		122,766,168	13,435	102,932	19,248,779	1,958	16,122	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		122,766,168	13,435	102,932	19,248,779	1,958	16,122	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,191,017	65,981,085	0.033207			50
51	Recovery Room	65,458	7,612,172	0.008599			51
52	Delivery Room & Labor Room	463,382	26,253,746	0.017650			52
53	Anesthesiology	143,656	12,928,889	0.011111			53
54	Radiology-Diagnostic	1,258,511	52,222,039	0.024099	7,418	179	54
55	Radiology-Therapeutic	1,329,511	12,593,252	0.105573			55
56	Radioisotope	49,641	11,458,585	0.004332			56
57	CT Scan	205,951	67,990,163	0.003029	9,709	29	57
58	MRI	185,794	26,028,017	0.007138	3,254	23	58
59	Cardiac Catheterization	431,623	21,379,619	0.020189			59
60	Laboratory	1,148,800	90,107,334	0.012749	180,523	2,301	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	77,035	8,571,681	0.008987			63
64	Intravenous Therapy	23,222	39,138,011	0.000593	31,099	18	64
65	Respiratory Therapy	376,570	31,456,285	0.011971	11,383	136	65
66	Physical Therapy	103,202	9,403,616	0.010975	7,133	78	66
69	Electrocardiology	144,898	32,747,332	0.004425	17,910	79	69
70	Electroencephalography	198,590	10,190,793	0.019487			70
71	Medical Supplies Charged to Pat	977,347	179,319,295	0.005450	4,659	25	71
72	Impl. Dev. Charged to Patients	765,244	75,790,918	0.010097			72
73	Drugs Charged to Patients	1,014,925	161,919,248	0.006268	213,219	1,336	73
74	Renal Dialysis	32,505	1,204,725	0.026981	2,371	64	74
76	GI LAB	401,657	12,576,703	0.031937			76
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	223,222	8,551,124	0.026104			90.01
90.02	ANTENATAL TEST CENTER	237,887	15,776,135	0.015079			90.02
90.03	CHILD PSYCHIATRIC CLINIC	19,036	211,000	0.090218			90.03
90.04	SPECIAL SURGICAL SERVICES	53,623	3,059,948	0.017524			90.04
90.05	GENETIC SERVICES	46,639	436,663	0.106808			90.05
91	Emergency	941,334	51,262,957	0.018363	148,948	2,735	91
92	Observation Beds (Non-Distinct		10,718,383				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	13,110,280	1,046,889,718		637,626	7,003	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					246,864		246,864	246,864	50
51	Recovery Room									51
52	Delivery Room & Labor Room					47,154		47,154	47,154	52
53	Anesthesiology									53
54	Radiology-Diagnostic					374,069		374,069	374,069	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
64	Intravenous Therapy									64
65	Respiratory Therapy					36,059		36,059	36,059	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
76.97	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
90.04	SPECIAL SURGICAL SERVICES									90.04
90.05	GENETIC SERVICES									90.05
91	Emergency					1,303,662		1,303,662	1,303,662	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)					2,007,808		2,007,808	2,007,808	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	65,981,085	0.003741	0.003741					50
51	Recovery Room	7,612,172							51
52	Delivery Room & Labor Room	26,253,746	0.001796	0.001796					52
53	Anesthesiology	12,928,889							53
54	Radiology-Diagnostic	52,222,039	0.007163	0.007163	7,418	53			54
55	Radiology-Therapeutic	12,593,252							55
56	Radioisotope	11,458,585							56
57	CT Scan	67,990,163			9,709		1,926		57
58	MRI	26,028,017			3,254				58
59	Cardiac Catheterization	21,379,619							59
60	Laboratory	90,107,334			180,523		876		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	8,571,681							63
64	Intravenous Therapy	39,138,011			31,099				64
65	Respiratory Therapy	31,456,285	0.001146	0.001146	11,383	13	66		65
66	Physical Therapy	9,403,616			7,133				66
69	Electrocardiology	32,747,332			17,910		314		69
70	Electroencephalography	10,190,793					3,590		70
71	Medical Supplies Charged to Pat	179,319,295			4,659		288		71
72	Impl. Dev. Charged to Patients	75,790,918							72
73	Drugs Charged to Patients	161,919,248			213,219				73
74	Renal Dialysis	1,204,725			2,371				74
76	GI LAB	12,576,703							76
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	8,551,124							90.01
90.02	ANTENATAL TEST CENTER	15,776,135							90.02
90.03	CHILD PSYCHIATRIC CLINIC	211,000							90.03
90.04	SPECIAL SURGICAL SERVICES	3,059,948							90.04
90.05	GENETIC SERVICES	436,663							90.05
91	Emergency	51,262,957	0.025431	0.025431	148,948	3,788			91
92	Observation Beds (Non-Distinct	10,718,383							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	1,046,889,718			637,626	3,854	7,060		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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.283701							50
51	Recovery Room	0.222570							51
52	Delivery Room & Labor Room	0.306771							52
53	Anesthesiology	0.114057							53
54	Radiology-Diagnostic	0.146220							54
55	Radiology-Therapeutic	0.346422							55
56	Radioisotope	0.114038							56
57	CT Scan	0.028501	1,926			55			57
58	MRI	0.060245							58
59	Cardiac Catheterization	0.120516							59
60	Laboratory	0.145714	876			128			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.207955							63
64	Intravenous Therapy	0.015118							64
65	Respiratory Therapy	0.157516	66			10			65
66	Physical Therapy	0.309460							66
69	Electrocardiology	0.085731	314			27			69
70	Electroencephalography	0.156379	3,590			561			70
71	Medical Supplies Charged to Pat	0.128464	288			37			71
72	Impl. Dev. Charged to Patients	0.237756							72
73	Drugs Charged to Patients	0.156623							73
74	Renal Dialysis	0.806459							74
76	GI LAB	0.133507							76
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	0.190574							90.01
90.02	ANTENATAL TEST CENTER	0.105403							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.232744							90.03
90.04	SPECIAL SURGICAL SERVICES	0.248141							90.04
90.05	GENETIC SERVICES	1.525403							90.05
91	Emergency	0.283628							91
92	Observation Beds (Non-Distinct)	0.671045							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	2.025393							95
200	Subtotal (see instructions)		7,060			818			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		7,060			818			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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,208,044		3,208,044	43,435	73.86	9,707	716,959	30
31	Intensive Care Unit	463,244		463,244	4,033	114.86	149	17,114	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE	602,971		602,971	14,352	42.01	2,049	86,078	34.01
34.02	PEDIATRIC INTENSIVE CARE	84,284		84,284	879	95.89	176	16,877	34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF	202,329		202,329	3,609	56.06	375	21,023	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	264,858		264,858	3,557	74.46	2,448	182,278	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	4,825,730		4,825,730	69,865		14,904	1,040,329	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0239

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,191,017	65,981,085	0.033207			50
51	Recovery Room	65,458	7,612,172	0.008599			51
52	Delivery Room & Labor Room	463,382	26,253,746	0.017650			52
53	Anesthesiology	143,656	12,928,889	0.011111			53
54	Radiology-Diagnostic	1,258,511	52,222,039	0.024099			54
55	Radiology-Therapeutic	1,329,511	12,593,252	0.105573			55
56	Radioisotope	49,641	11,458,585	0.004332			56
57	CT Scan	205,951	67,990,163	0.003029			57
58	MRI	185,794	26,028,017	0.007138			58
59	Cardiac Catheterization	431,623	21,379,619	0.020189			59
60	Laboratory	1,148,800	90,107,334	0.012749			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	77,035	8,571,681	0.008987			63
64	Intravenous Therapy	23,222	39,138,011	0.000593			64
65	Respiratory Therapy	376,570	31,456,285	0.011971			65
66	Physical Therapy	103,202	9,403,616	0.010975			66
69	Electrocardiology	144,898	32,747,332	0.004425			69
70	Electroencephalography	198,590	10,190,793	0.019487			70
71	Medical Supplies Charged to Pat	977,347	179,319,295	0.005450			71
72	Impl. Dev. Charged to Patients	765,244	75,790,918	0.010097			72
73	Drugs Charged to Patients	1,014,925	161,919,248	0.006268			73
74	Renal Dialysis	32,505	1,204,725	0.026981			74
76	GI LAB	401,657	12,576,703	0.031937			76
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	223,222	8,551,124	0.026104			90.01
90.02	ANTENATAL TEST CENTER	237,887	15,776,135	0.015079			90.02
90.03	CHILD PSYCHIATRIC CLINIC	19,036	211,000	0.090218			90.03
90.04	SPECIAL SURGICAL SERVICES	53,623	3,059,948	0.017524			90.04
90.05	GENETIC SERVICES	46,639	436,663	0.106808			90.05
91	Emergency	941,334	51,262,957	0.018363			91
92	Observation Beds (Non-Distinct	495,146	10,718,383	0.046196			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	13,605,426	1,046,889,718				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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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: [XX] Title XIX [XX] Other

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)				175,540			175,540	30
31	Intensive Care Unit				14,182			14,182	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
34.01	NEONATAL INTENSIVE CARE				131,438			131,438	34.01
34.02	PEDIATRIC INTENSIVE CARE				4,048			4,048	34.02
35	Other Special Care (specify)								35
40	Subprovider - IPF				11,668			11,668	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery				8,008			8,008	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)				344,884			344,884	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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)	43,435	4.04	9,707	39,216	30
31	Intensive Care Unit	4,033	3.52	149	524	31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
34.01	NEONATAL INTENSIVE CARE	14,352	9.16	2,049	18,769	34.01
34.02	PEDIATRIC INTENSIVE CARE	879	4.61	176	811	34.02
35	Other Special Care (specify)					35
40	Subprovider - IPF	3,609	3.23	375	1,211	40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	3,557	2.25	2,448	5,508	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	69,865		14,904	66,039	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					246,864		246,864	246,864	50
51	Recovery Room									51
52	Delivery Room & Labor Room					47,154		47,154	47,154	52
53	Anesthesiology									53
54	Radiology-Diagnostic					374,069		374,069	374,069	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
64	Intravenous Therapy									64
65	Respiratory Therapy					36,059		36,059	36,059	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
76.97	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
90.04	SPECIAL SURGICAL SERVICES									90.04
90.05	GENETIC SERVICES									90.05
91	Emergency					1,303,662		1,303,662	1,303,662	91
92	Observation Beds (Non-Distinct					27,093		27,093	27,093	92
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)					2,034,901		2,034,901	2,034,901	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0239

**WORKSHEET D
PART IV**

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	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
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra								63
64	Intravenous Therapy								64
65	Respiratory Therapy								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
76.97	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
90.04	SPECIAL SURGICAL SERVICES								90.04
90.05	GENETIC SERVICES								90.05
91	Emergency								91
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)								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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 Hospital SUB (Other) Swing Bed SNF
 Applicable 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							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
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
64	Intravenous Therapy							64
65	Respiratory Therapy							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
76.97	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
90.04	SPECIAL SURGICAL SERVICES							90.04
90.05	GENETIC SERVICES							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 IPF
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,191,017	65,981,085	0.033207			50
51	Recovery Room	65,458	7,612,172	0.008599			51
52	Delivery Room & Labor Room	463,382	26,253,746	0.017650			52
53	Anesthesiology	143,656	12,928,889	0.011111			53
54	Radiology-Diagnostic	1,258,511	52,222,039	0.024099			54
55	Radiology-Therapeutic	1,329,511	12,593,252	0.105573			55
56	Radioisotope	49,641	11,458,585	0.004332			56
57	CT Scan	205,951	67,990,163	0.003029			57
58	MRI	185,794	26,028,017	0.007138			58
59	Cardiac Catheterization	431,623	21,379,619	0.020189			59
60	Laboratory	1,148,800	90,107,334	0.012749			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	77,035	8,571,681	0.008987			63
64	Intravenous Therapy	23,222	39,138,011	0.000593			64
65	Respiratory Therapy	376,570	31,456,285	0.011971			65
66	Physical Therapy	103,202	9,403,616	0.010975			66
69	Electrocardiology	144,898	32,747,332	0.004425			69
70	Electroencephalography	198,590	10,190,793	0.019487			70
71	Medical Supplies Charged to Pat	977,347	179,319,295	0.005450			71
72	Impl. Dev. Charged to Patients	765,244	75,790,918	0.010097			72
73	Drugs Charged to Patients	1,014,925	161,919,248	0.006268			73
74	Renal Dialysis	32,505	1,204,725	0.026981			74
76	GI LAB	401,657	12,576,703	0.031937			76
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	223,222	8,551,124	0.026104			90.01
90.02	ANTENATAL TEST CENTER	237,887	15,776,135	0.015079			90.02
90.03	CHILD PSYCHIATRIC CLINIC	19,036	211,000	0.090218			90.03
90.04	SPECIAL SURGICAL SERVICES	53,623	3,059,948	0.017524			90.04
90.05	GENETIC SERVICES	46,639	436,663	0.106808			90.05
91	Emergency	941,334	51,262,957	0.018363			91
92	Observation Beds (Non-Distinct		10,718,383				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	13,110,280	1,046,889,718				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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room					246,864		246,864	246,864	50
51	Recovery Room									51
52	Delivery Room & Labor Room					47,154		47,154	47,154	52
53	Anesthesiology									53
54	Radiology-Diagnostic					374,069		374,069	374,069	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
63	Blood Storing, Processing & Tra									63
64	Intravenous Therapy									64
65	Respiratory Therapy					36,059		36,059	36,059	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
76.97	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
90.04	SPECIAL SURGICAL SERVICES									90.04
90.05	GENETIC SERVICES									90.05
91	Emergency					1,303,662		1,303,662	1,303,662	91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)					2,007,808		2,007,808	2,007,808	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 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)	
		7	8	9	10	11	12	13	
	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
57	CT Scan								57
58	MRI								58
59	Cardiac Catheterization								59
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra								63
64	Intravenous Therapy								64
65	Respiratory Therapy								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
76.97	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
90.04	SPECIAL SURGICAL SERVICES								90.04
90.05	GENETIC SERVICES								90.05
91	Emergency								91
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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.)
		1	2	3	4	5	6	7
	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
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra							63
64	Intravenous Therapy							64
65	Respiratory Therapy							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
76.97	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
90.04	SPECIAL SURGICAL SERVICES							90.04
90.05	GENETIC SERVICES							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,435	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,435	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)	36,731	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)	13,271	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)	46,599,929	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)	46,599,929	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)	46,599,929	37

KPMG LLP Compu-Max 2552-10

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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	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,072.87	38	
39	Program general inpatient routine service cost (line 9 x line 38)					14,238,058	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)					14,238,058	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	6,924,784	4,033	1,717.03	2,000	3,434,060	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
46.01	NEONATAL INTENSIVE CARE	12,118,389	14,352	844.37			46.01	
46.02	PEDIATRIC INTENSIVE CARE	2,081,549	879	2,368.09			46.02	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					24,111,050	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					41,783,168	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,270,571	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,902,503	51
52	Total Program excludable cost (sum of lines 50 and 51)					3,173,074	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					38,610,094	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

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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)					6,704	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,072.87	88
89	Observation bed cost (line 87 x line 88) (see instructions)					7,192,520	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	3,208,044	46,599,929	0.068842	7,192,520	495,147	90
91	Nursing School						91
92	Allied Health	175,540	46,599,929	0.003767	7,192,520	27,094	92
93	Other Medical Education						93

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 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)	3,609	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,609	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)	3,609	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)	963	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,475,994	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,475,994	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,475,994	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	963.15	38
39	Program general inpatient routine service cost (line 9 x line 38)	927,513	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)	927,513	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	112,022	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,039,535	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	57,096	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,857	51
52	Total Program excludable cost (sum of lines 50 and 51)	67,953	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	971,582	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

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	43,435	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	43,435	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)	36,731	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)	9,707	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)	3,557	15
16	Nursery days (title V or XIX only)	2,448	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)	47,855,317	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)	47,855,317	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)	47,855,317	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0239

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,101.77	38	
39	Program general inpatient routine service cost (line 9 x line 38)					10,694,881	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)					10,694,881	41	
42	Nursery (Titles V and XIX only)	4,454,861	3,557	1,252.42	2,448	3,065,924	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	6,924,784	4,033	1,717.03	149	255,837	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
46.01	NEONATAL INTENSIVE CARE	12,118,389	14,352	844.37	2,049	1,730,114	46.01	
46.02	PEDIATRIC INTENSIVE CARE	2,081,549	879	2,368.09	176	416,784	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)					16,163,540	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,084,134	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					1,084,134	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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)					6,704	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,101.77	88
89	Observation bed cost (line 87 x line 88) (see instructions)					7,386,266	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	3,208,044	47,855,317	0.067036	7,386,266	495,146	90
91	Nursing School						91
92	Allied Health	175,540	47,855,317	0.003668	7,386,266	27,093	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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 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)	3,609	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,609	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)	3,609	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)	375	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,475,994	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,475,994	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,475,994	37

KPMG LLP Compu-Max 2552-10

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S239

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	963.15	38
39	Program general inpatient routine service cost (line 9 x line 38)	361,181	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)	361,181	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)	361,181	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	22,234	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)	22,234	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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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		15,645,424		30
31	Intensive Care Unit		4,813,882		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	0.284362	8,959,970	2,547,875	50
51	Recovery Room	0.222570	1,046,793	232,985	51
52	Delivery Room & Labor Room	0.306771	175,061	53,704	52
53	Anesthesiology	0.114057	1,580,670	180,286	53
54	Radiology-Diagnostic	0.146220	8,103,614	1,184,910	54
55	Radiology-Therapeutic	0.346422	125,261	43,393	55
56	Radioisotope	0.114038	1,007,757	114,923	56
57	CT Scan	0.028501	8,036,241	229,041	57
58	MRI	0.060245	1,851,963	111,572	58
59	Cardiac Catheterization	0.120516	4,192,134	505,219	59
60	Laboratory	0.145714	16,988,521	2,475,465	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.207955	1,700,977	353,727	63
64	Intravenous Therapy	0.015118	1,780,898	26,924	64
65	Respiratory Therapy	0.157516	5,636,803	887,887	65
66	Physical Therapy	0.309460	2,550,931	789,411	66
69	Electrocardiology	0.085731	4,856,764	416,375	69
70	Electroencephalography	0.156379	263,779	41,249	70
71	Medical Supplies Charged to Patients	0.128464	33,756,315	4,336,471	71
72	Impl. Dev. Charged to Patients	0.237756	14,708,845	3,497,116	72
73	Drugs Charged to Patients	0.156623	23,393,068	3,663,892	73
74	Renal Dialysis	0.806459	581,193	468,708	74
76	GI LAB	0.133507	1,544,075	206,145	76
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	0.190574	23,471	4,473	90.01
90.02	ANTENATAL TEST CENTER	0.105403	19,928	2,100	90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.232744			90.03
90.04	SPECIAL SURGICAL SERVICES	0.248141	3,245	805	90.04
90.05	GENETIC SERVICES	1.525403	224	342	90.05
91	Emergency	0.283644	4,987,760	1,414,748	91
92	Observation Beds (Non-Distinct Part)	0.671045	478,812	321,304	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		148,355,073	24,111,050	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		148,355,073		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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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		1,369,224		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.284362			50
51	Recovery Room	0.222570			51
52	Delivery Room & Labor Room	0.306771			52
53	Anesthesiology	0.114057			53
54	Radiology-Diagnostic	0.146220	7,418	1,085	54
55	Radiology-Therapeutic	0.346422			55
56	Radioisotope	0.114038			56
57	CT Scan	0.028501	9,709	277	57
58	MRI	0.060245	3,254	196	58
59	Cardiac Catheterization	0.120516			59
60	Laboratory	0.145714	180,523	26,305	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.207955			63
64	Intravenous Therapy	0.015118	31,099	470	64
65	Respiratory Therapy	0.157516	11,383	1,793	65
66	Physical Therapy	0.309460	7,133	2,207	66
69	Electrocardiology	0.085731	17,910	1,535	69
70	Electroencephalography	0.156379			70
71	Medical Supplies Charged to Patients	0.128464	4,659	599	71
72	Impl. Dev. Charged to Patients	0.237756			72
73	Drugs Charged to Patients	0.156623	213,219	33,395	73
74	Renal Dialysis	0.806459	2,371	1,912	74
76	GI LAB	0.133507			76
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	0.190574			90.01
90.02	ANTENATAL TEST CENTER	0.105403			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.232744			90.03
90.04	SPECIAL SURGICAL SERVICES	0.248141			90.04
90.05	GENETIC SERVICES	1.525403			90.05
91	Emergency	0.283644	148,948	42,248	91
92	Observation Beds (Non-Distinct Part)	0.671045			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		637,626	112,022	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		637,626		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: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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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)	7,297,338			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	22,584,909			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)	1,709,597			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	14,194,124			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	296.31			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)	0.66			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)	0.66			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	0.39			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	0.39			12
13	Total allowable FTE count for the prior year	0.35			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	0.35			14
15	Sum of lines 12 through 14 divided by 3	0.36			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	0.36			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.001215			19
20	Prior year resident to bed ratio (see instructions)	0.001179			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.001179			21
22	IME payment adjustment (see instructions)	19,244			22
22.01	IME payment adjustment - Managed Care (see instructions)	9,141			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)	-0.27			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)	19,244			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	9,141			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0491			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4269			31
32	Sum of lines 30 and 31	0.4760			32
33	Allowable disproportionate share percentage (see instructions)	0.2848			33
34	Disproportionate share adjustment (see instructions)	2,127,617			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000571582	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,782,557		3,867,721	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	953,412		2,892,843	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,846,255			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
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	37,584,960			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)	37,594,101			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,803,252			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)	11,080			52
53	Nursing and allied health managed care payment	209,646			53
54	Special add-on payments for new technologies	6,286			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).	60,655			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	226,393			58
59	Total (sum of amounts on lines 49 through 58)	40,911,413			59
60	Primary payer payments	15,348			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	40,896,065			61
62	Deductibles billed to program beneficiaries	3,119,504			62
63	Coinsurance billed to program beneficiaries	74,985			63
64	Allowable bad debts (see instructions)	1,354,837			64
65	Adjusted reimbursable bad debts (see instructions)	880,644			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,149,572			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	38,582,220			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)	-230,461			70.93
70.94	HRR adjustment amount (see instructions)	-425,633			70.94
70.99	HAC adjustment amount (see instructions)	96,922			70.99
71	Amount due provider (see instructions)	37,829,204			71
71.01	Sequestration adjustment (see instructions)	756,584			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	36,020,036			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	1,052,584			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	4,464,378			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
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	7,297,338	7,297,338			7,297,338	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	22,584,909		22,584,909		22,584,909	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges	1,709,597	380,385		1,329,212	1,709,597	2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments	14,194,124	3,229,639		10,964,485	14,194,124	4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21	0.001179	0.001179		0.001179		5
6	IME payment adjustment	19,244	4,699		14,545	19,244	6
6.01	IME payment adjustment for managed care	9,141	2,080		7,061	9,141	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)	19,244	4,699		14,545	19,244	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	9,141	2,080		7,061	9,141	9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage	0.2848	0.2848	0.2848	0.2848	0.2848	10
11	Disproportionate share adjustment	2,127,617	519,571		1,608,046	2,127,617	11
11.01	Uncompensated care payments	3,846,255	953,412		2,892,843	3,846,255	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	37,584,960	9,155,405		28,429,555	37,584,960	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)						14
15	Total payment for inpatient operating costs SCH and MDH only	37,594,101	9,157,485		28,436,616	37,594,101	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	2,803,252	679,391		2,123,861	2,803,252	16
17	Special add-on payments for new technologies	6,286	1,036		5,250	6,286	17
17.01	DO NOT USE THIS LINE						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL		9,837,912		30,565,727	40,403,639	19
20	Capital DRG other than outlier	2,430,027	590,818		1,839,209	2,430,027	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	125,848	28,428		97,420	125,848	21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage	0.0600	0.0600		0.0600		22
23	Indirect medical education adjustment	1,458	354		1,104	1,458	23
24	Allowable disproportionate share percentage	0.1012	0.1012		0.1012		24
25	Disproportionate share adjustment	245,919	59,791		186,128	245,919	25
26	Total prospective capital payments	2,803,252	679,391		2,123,861	2,803,252	26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1						29
30	HVBP payment adjustment	-230,461	-56,673		-173,788	-230,461	30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment	-425,633	-89,040		336,593	247,553	31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment		96,922			96,922	32

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)	18,080			1
2	Medical and other services reimbursed under OPPS (see instructions)	19,030,123			2
3	OPPS payments	18,172,858			3
4	Outlier payment (see instructions)	114,414			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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	218,656			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	18,080			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	116,367			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)	116,367			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)	116,367			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	98,287			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 (see instructions)	18,080			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, 4.01, 8 and 9)	18,505,928			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,426,638			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)	15,097,370			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	4,987			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	15,102,357			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	15,102,357			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)	1,067,206			34
35	Adjusted reimbursable bad debts (see instructions)	693,684			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	853,471			36
37	Subtotal (see instructions)	15,796,041			37
38	MSP-LCC reconciliation amount from PS&R	713			38
39	Other adjustments (FORMULA DRIVEN OVERPAYMENT EST)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	15,795,328			40
40.01	Sequestration adjustment (see instructions)	315,907			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	15,259,845			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	219,576			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S239

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions)	818		2
3	OPPS payments	344		3
4	Outlier payment (see instructions)			4
4.01	Outlier reconciliation amount (see instructions)			4.01
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of lines 3, 4, and 4.01, 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 (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, 4.01, 8 and 9)	344		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	69		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)	275		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)	275		30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)	275		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)	275		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)	275		40
40.01	Sequestration adjustment (see instructions)	6		40.01
40.02	Demonstration payment adjustment amount after sequestration			40.02
41	Interim payments	270		41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)	-1		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

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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		36,061,536		15,310,645	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
			02/06/2018	41,500	02/06/2018	50,800
						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)	.99	-41,500		-50,800	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)		36,020,036		15,259,845	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)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	1,052,584		219,576	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		37,072,620		15,479,421	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S239

WORKSHEET E-1
PART I

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

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		717,430		270
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				
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)		717,430		270
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			6.01
		.02			6.02
			-13,806		-1
7	Total Medicare program liability (see instructions)		703,624		269
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

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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)	827,512	1
2	Net IPF PPS Outlier payment	3,237	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)	9,887,671	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)	830,749	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)	830,749	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	830,749	18
19	Deductibles	95,664	19
20	Subtotal (line 18 minus line 19)	735,085	20
21	Coinsurance	24,065	21
22	Subtotal (line 20 minus line 21)	711,020	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)	711,020	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)	6,964	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)	717,984	31
31.01	Sequestration adjustment (see instructions)	14,360	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	717,430	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-13,806	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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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			0.66	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			0.66	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.39	6
7	Enter the lesser of line 5 or line 6			0.39	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.39	0.00	0.39	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.39	0.00	0.39	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.39	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.35	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.35	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.36	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.36	0.00		17
18	Per resident amount	124,615.55	118,437.48		18
19	Approved amount for resident costs	44,862		44,862	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			44,862	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	16,234	7,436		26
27	Total inpatient days (see instructions)	63,161	63,161		27
28	Ratio of inpatient days to total inpatient days	0.257026	0.117731		28
29	Program direct GME amount	11,531	5,282		29
30	Reduction for direct GME payments for Medicare Advantage		746		30
31	Net Program direct GME amount			16,067	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,204,725	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			42,822,703	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			15,348	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			42,807,355	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			19,267,677	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			19,267,677	44
45	Total reasonable cost (sum of lines 41 and 44)			62,075,032	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.689607	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.310393	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			16,067	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			11,080	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			4,987	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check Title V
 Applicable Title XVIII
 Box: Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			10.01
11	Total weighted FTE count	0.00	0.00	11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	14
15	Adjustment for residents in initial years of new programs	0.00	0.00	15
15.01	Unweighted adjustment for residents in initial years of new programs			15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16.01
17	Adjusted rolling average FTE count	0.00	0.00	17
18	Per resident amount	0.00	0.00	18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)			21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 times line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	12,456	13,034	26
27	Total inpatient days (see instructions)	63,161	63,161	27
28	Ratio of inpatient days to total inpatient days	0.197210	0.206362	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			30
31	Net Program direct GME amount			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			50

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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)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	70,867,986				1
2	Temporary investments					2
3	Notes receivable	37,540				3
4	Accounts receivable	56,034,042				4
5	Other receivables	16,292,063				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	8,175,848				7
8	Prepaid expenses	2,859,357				8
9	Other current assets	8,000,000				9
10	Due from other funds	1,118,122				10
11	Total current assets (sum of lines 1-10)	163,384,958				11
FIXED ASSETS						
12	Land	8,437,914				12
13	Land improvements	7,953,249				13
14	Accumulated depreciation	-6,995,784				14
15	Buildings	56,812,576				15
16	Accumulated depreciation	-44,218,564				16
17	Leasehold improvements	348,669,579				17
18	Accumulated depreciation	-107,271				18
19	Fixed equipment	139,668,450				19
20	Accumulated depreciation	-105,154,495				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	164,341,687				23
24	Accumulated depreciation	-131,916,496				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)	437,490,845				30
OTHER ASSETS						
31	Investments	256,013,798				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	16,155,329				34
35	Total other assets (sum of lines 31-34)	272,169,127				35
36	Total assets (sum of lines 11, 30 and 35)	873,044,930				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	31,489,686				37
38	Salaries, wages and fees payable	29,329,654				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	21,875,025				44
45	Total current liabilities (sum of lines 37 thru 44)	82,694,365				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	460,615,000				47
48	Unsecured loans					48
49	Other long term liabilities	97,770,305				49
50	Total long term liabilities (sum of lines 46 thru 49)	558,385,305				50
51	Total liabilities (sum of lines 45 and 50)	641,079,670				51
CAPITAL ACCOUNTS						
52	General fund balance	231,965,260				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)	231,965,260				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	873,044,930				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		217,115,540			1
2	Net income (loss) (from Worksheet G-3, line 29)		61,714,950			2
3	Total (sum of line 1 and line 2)		278,830,490			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)		278,830,490			11
12	Deductions (debit adjustments) (specify)	46,865,230				12
13	TRANFERS					13
14						14
15						15
16	OTHER					16
17						17
18	Total deductions (sum of lines 12-17)		46,865,230			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		231,965,260			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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	63,240,651		63,240,651	1
2	Subprovider IPF	5,138,823		5,138,823	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)	68,379,474		68,379,474	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	18,650,148		18,650,148	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
14.01	NEONATAL INTENSIVE CARE	85,727,659		85,727,659	14.01
14.02	PEDIATRIC INTENSIVE CARE	4,506,326		4,506,326	14.02
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	108,884,133		108,884,133	16
17	Total inpatient routine care services (sum of lines 10 and 16)	177,263,607		177,263,607	17
18	Ancillary services	456,812,779		456,812,779	18
19	Outpatient services		547,578,206	547,578,206	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				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)	634,076,386	547,578,206	1,181,654,592	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		327,181,927	29
30	Add (specify)			30
31	BAD DEBTS	13,090,794		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		13,090,794	36
37	Deduct (specify)			37
38	PHYSICIAN PRACTICE REVENUE			38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		340,272,721	43

KPMG LLP Compu-Max 2552-10

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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)	1,181,654,592	1
2	Less contractual allowances and discounts on patients' accounts	810,852,428	2
3	Net patient revenues (line 1 minus line 2)	370,802,164	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	340,272,721	4
5	Net income from service to patients (line 3 minus line 4)	30,529,443	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)	22,661,561	24
24.01	Other (OTHER NON-OPERATING INCOME)	8,523,946	24.01
24.02	Other (PROVIDER TAX)		24.02
25	Total other income (sum of lines 6-24)	31,185,507	25
26	Total (line 5 plus line 25)	61,714,950	26
29	Net income (or loss) for the period (line 26 minus line 28)	61,714,950	29

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 10:48 Version: 2018.04 (09/26/2018)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0239

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	2,430,027	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	125,848	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	163.16	3
4	Number of interns & residents (see instructions)	0.36	4
5	Indirect medical education percentage (see instructions)	0.06	5
6	Indirect medical education adjustment (see instructions)	1,458	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0491	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4269	8
9	Sum of lines 7 and 8	0.4760	9
10	Allowable disproportionate share percentage (see instructions)	0.1012	10
11	Disproportionate share adjustment (see instructions)	245,919	11
12	Total prospective capital payments (see instructions)	2,803,252	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMDICAL ED PROGRAM XRAY							23
23.01	PASTORAL EDUCATION PROGRAM							23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
34.01	NEONATAL INTENSIVE CARE							34.01
34.02	PEDIATRIC INTENSIVE CARE							34.02
40	Subprovider - IPF							40
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.							63
64	Intravenous Therapy							64
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
76.97	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
90.04	SPECIAL SURGICAL SERVICES							90.04
90.05	GENETIC SERVICES							90.05
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
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							

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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) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
192	Physicians' Private Offices	0	2A	24	25	26		192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER							194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES							194.02
194.04	AUXILIARY							194.04
194.08	DIALYSIS RENTED SPACE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202