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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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. [X] ELECTRONICALLY FILED COST REPORT DATE: 05/22/2014 TIME: 07:53 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] 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. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ROCKFORD MEMORIAL HOSPITAL (14-0239) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		514,801	-194,866	-62,019		1
2	SUBPROVIDER - IPF		25,682				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		540,483	-194,866	-62,019		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 OMD 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

HOSPITAL AND HOSPITAL HEALTHCARE 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	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ROCKFORD MEMORIAL HOSPITAL	14-0239	40420	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF	RMH PSYCHIATRIC UNIT	14-S239	40420	4	03/01/1990	N	P	O	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19

20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013	20
21	TYPE OF CONTROL (see instructions)	2		21

	INPATIENT PPS INFORMATION	1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY 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)	N	Y	22.01
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 COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	17,588	2,900		79	983	715	24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		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	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	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	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	Y			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
		1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER 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 NON-PROVIDER 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 NON-PROVIDER 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 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
	ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			N	N		71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						76

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: 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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					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
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
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.	N	N	N	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 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'		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:		4,684,529			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	149018	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: ROCKFORD HEALTH SYSTEM	CONTRACTOR'S NAME: WISCONSIN PHYSICIANS SERVICE CONTRACTOR'S NUMBER: 65235		141
142	STREET: 2400 NORTH ROCKTON AVENUE	P.O. BOX:		142
143	CITY: ROCKFORD	STATE: IL	ZIP CODE: 61103	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	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.		166

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	01/01/2013	12/31/2013	170

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1

		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3

		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5

		Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	Y		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

		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			
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
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	04/08/2014	Y	04/08/2014	17
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		18
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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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 COSTS			
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 CAPITALIZED 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

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE 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 REORT PREPARER INFORMATION				
41	FIRST NAME: GARY	LAST NAME: ZEMAN	TITLE: SENIOR MGR	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.			42
43	PHONE NUMBER: 630-530-7100	E-MAIL ADDRESS: GARY.ZEMAN@SRINC.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		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	212	77,991			20,788	7,755	46,401	1
2	HMO AND OTHER (see instructions)						4,730	4,677		2
3	HMO IPF SUBPROVIDER						140			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)		212	77,991			20,788	7,755	46,401	7
8	INTENSIVE CARE UNIT	31	21	7,665			2,310	826	5,496	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
11.01	NEONATAL INTENSIVE CARE	34.01	46	16,790				6,606	11,545	11.01
11.02	PEDIATRIC INTENSIVE CARE	34.02	7	2,555				842	1,131	11.02
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						1,303	2,491	13
14	TOTAL (see instructions)		286	105,001			23,098	17,332	67,064	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	14	4,930			1,304	745	4,084	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		300							27
28	OBSERVATION BED DAYS								5,103	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							256	417	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					4,412	3,231	12,532	1
2	HMO AND OTHER (see instructions)					914			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
11.01	NEONATAL INTENSIVE CARE								11.01
11.02	PEDIATRIC INTENSIVE CARE								11.02
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		1,844.36			4,412	3,231	12,532	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		23.07			162	138	640	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		1,867.43						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	107,916,966		107,916,966	3,894,932.00	27.71	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		3,100,401	60,105	3,160,506	84,240.00	37.52	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		3,420,755		3,420,755	57,785.00	59.20	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		7,649,244		7,649,244	48,028.00	159.27	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		11,057,075		11,057,075	76,129.00	145.24	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		34,140,740		34,140,740			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		555,667		555,667			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		2,484,679		2,484,679	116,134.00	21.39	26
27	ADMINISTRATIVE & GENERAL		17,772,931	-60,105	17,712,826	484,139.00	36.59	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		2,782,056		2,782,056	125,429.00	22.18	30
31	LAUNDRY & LINEN SERVICE		108,722		108,722	8,858.00	12.27	31
32	HOUSEKEEPING		1,996,189		1,996,189	156,621.00	12.75	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		2,215,508	-1,505,292	710,216	53,378.00	13.31	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			1,505,292	1,505,292	113,135.00	13.31	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		2,590,666		2,590,666	80,988.00	31.99	38
39	CENTRAL SERVICES AND SUPPLY		1,321,954		1,321,954	80,122.00	16.50	39
40	PHARMACY		3,774,515		3,774,515	94,129.00	40.10	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,646,109		1,646,109	90,171.00	18.26	41
42	SOCIAL SERVICE		285,594		285,594	10,308.00	27.71	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	107,916,966		107,916,966	3,894,932.00	27.71	1
2	EXCLUDED AREA SALARIES (see instructions)	3,100,401	60,105	3,160,506	84,240.00	37.52	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	104,816,565	-60,105	104,756,460	3,810,692.00	27.49	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	22,127,074		22,127,074	181,942.00	121.62	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	34,140,740		34,140,740		32.59%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		161,084,379	-60,105	161,024,274	3,992,634.00	40.33	6
7	TOTAL OVERHEAD COST (see instructions)		36,978,923	-60,105	36,918,818	1,413,412.00	26.12	7

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	2,203,036	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	2,786,213	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	17,554,197	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	574,586	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	29,574	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	1,237,662	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	1,269,608	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	816,198	16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	6,847,455	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	307,260	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	514,951	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	34,140,740	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

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

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		OUTPATIENT		TRAINING		HOME		
	DESCRIPTION	REGULAR	HIGH FLUX	HEMO-DIALYSIS	CAPD CCPD	HEMO-DIALYSIS	CAPD CCPD	
		1	2	3	4	5	6	
1	NUMBER OF PATIENTS IN PROGRAM AT END OF COST REPORTING PERIOD							1
2	NUMBER OF TIMES PER WEEK PATIENT RECEIVES DIALYSIS							2
3	AVERAGE PATIENT DIALYSIS TIME INCLUDING SETUP							3
4	CAPD EXCHANGES PER DAY							4
5	NUMBER OF DAYS IN YEAR DIALYSIS FURNISHED							5
6	NUMBER OF STATIONS							6
7	TREATMENT CAPACITY PER DAY PER STATION							7
8	UTILIZATION (see instructions)							8
9	AVERAGE TIMES DIALYZERS RE-USED							9
10	PERCENTAGE OF PATIENTS RE-USING DIALYZERS							10

ESRD PPS

		1	2	
10.01	IS THE DIALYSIS FACILITY APPROVED AS A LOW-VOLUME FACILITY FOR THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)			10.01
10.02	DID YOUR FACILITY ELECT 100% PPS EFFECTIVE JANUARY 1, 2011? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions for 'new' providers)			10.02
10.03	IF YOU RESPONDED 'N' TO LINE 10.02, ENTER IN COLUMN 1 THE YEAR OF TRANSITION FOR PERIODS PRIOR TO JANUARY 1 AND ENTER IN COLUMN 2 THE YEAR OF TRANSITION FOR PERIODS AFTER DECEMBER 31. (see instructions)			10.03

TRANSPLANT INFORMATION

11	NUMBER OF PATIENTS ON TRANSPLANT LIST		11
12	NUMBER OF PATIENTS TRANSPLANTED DURING THE COST REPORTING PERIOD		12

EPOETIN

13	NET COSTS OF EPOETIN FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		13
14	EPOETIN AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		14
15	NUMBER OF EPO UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		15
16	NUMBER OF EPO UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		16

ARANESP

17	NET COSTS OF ARANESP FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER		17
18	ARANESP AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM		18
19	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT		19
20	NUMBER OF ARANESP UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT		20

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

21	MCP X	INITIAL METHOD	

	ERYTHROPOIESIS-STIMULATING AGENTS (ESA) STATISTICS:	ESA DESCRIPTION	NET COST OF ESAs FOR RENAL PATIENTS	NET COST OF ESAs FOR HOME PATIENTS	NUMBER OF ESA UNITS - RENAL DIALYSIS DEPT.	NUMBER OF ESA UNITS - HOME DIALYSIS DEPT.	
		1	2	3	4	5	
22	ENTER IN COLUMN 1 THE ESA DESCRIPTION. ENTER IN COLUMN 2 THE NET COSTS OF ESAs FURNISHED TO ALL RENAL DIALYSIS PATIENTS. ENTER IN COLUMN 3 THE NET COST OF ESAs FURNISHED TO ALL HOME DIALYSIS PROGRAM PATIENTS. ENTER IN COLUMN 4 THE NUMBER OF ESA UNITS FURNISHED TO PATIENTS IN THE RENAL DIALYSIS DEPARTMENT. ENTER IN COLUMN 5 THE NUMBER OF UNITS FURNISHED TO PATIENTS IN THE HOME DIALYSIS PROGRAM. (see instructions)						22

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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)	0.311269	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	45,697,511	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	15,381,111	5
6	MEDICAID CHARGES	175,752,945	6
7	MEDICAID COST (line 1 times line 6)	54,706,443	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	31,754,913		31,754,913	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	9,884,320		9,884,320	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	9,884,320		9,884,320	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	18,971,665	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	731,042	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	18,240,623	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	5,677,740	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	15,562,060	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	15,562,060	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				242,018	242,018	-57,670	184,348	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,767,023	1,767,023	14,124,964	15,891,987	-2,371	15,889,616	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	2,484,679	2,913,254	5,397,933	-42,423	5,355,510	-1,644,261	3,711,249	4
5	00500	ADMINISTRATIVE & GENERAL	17,772,931	52,619,244	70,392,175	-4,613,231	65,778,944	-350,195	65,428,749	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	2,782,056	10,438,438	13,220,494	-894,780	12,325,714	-28,805	12,296,909	7
8	00800	LAUNDRY & LINEN SERVICE	108,722	1,068,201	1,176,923	-9,057	1,167,866		1,167,866	8
9	00900	HOUSEKEEPING	1,996,189	1,402,047	3,398,236	-25,050	3,373,186		3,373,186	9
10	01000	DIETARY	2,215,508	3,214,133	5,429,641	-3,918,981	1,510,660		1,510,660	10
11	01100	CAFETERIA				3,847,550	3,847,550	-1,787,880	2,059,670	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,590,666	1,142,012	3,732,678	-15,155	3,717,523	-130,208	3,587,315	13
14	01400	CENTRAL SERVICES & SUPPLY	1,321,954	2,726,668	4,048,622	-979,831	3,068,791	-24,611	3,044,180	14
15	01500	PHARMACY	3,774,515	15,704,283	19,478,798	-14,111,665	5,367,133		5,367,133	15
16	01600	MEDICAL RECORDS & LIBRARY	1,646,109	1,341,701	2,987,810	-28,329	2,959,481	-24,632	2,934,849	16
17	01700	SOCIAL SERVICE	285,594	264,065	549,659		549,659	-6,830	542,829	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMDICAL ED PROGRAM XRAY	152,288	41,743	194,031	-90	193,941	-21,439	172,502	23
23.01	02301	PASTORAL EDUCATION PROGRAM				77,644	77,644	-4,225	73,419	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	350,172	321,480	671,652	14,507	686,159	-74,405	611,754	23.02
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	21,134,015	12,084,113	33,218,128	-3,715,241	29,502,887	-66,878	29,436,009	30
31	03100	INTENSIVE CARE UNIT	3,908,724	5,103,990	9,012,714	-726,291	8,286,423		8,286,423	31
34.01	03401	NEONATAL INTENSIVE CARE	6,559,850	3,750,794	10,310,644	-2,350,578	7,960,066	-41,980	7,918,086	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	966,315	516,897	1,483,212	-70,499	1,412,713	-10,936	1,401,777	34.02
40	04000	SUBPROVIDER - IPF	1,317,743	806,480	2,124,223	-56,933	2,067,290	-18,800	2,048,490	40
43	04300	NURSERY				2,687,882	2,687,882		2,687,882	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	7,085,260	23,067,144	30,152,404	-15,488,498	14,663,906	-981,870	13,682,036	50
51	05100	RECOVERY ROOM	999,257	422,897	1,422,154	-37,346	1,384,808		1,384,808	51
52	05200	DELIVERY ROOM & LABOR ROOM	2,409,087	2,447,418	4,856,505	-463,358	4,393,147	-51,344	4,341,803	52
53	05300	ANESTHESIOLOGY	342,436	3,823,187	4,165,623	-284,661	3,880,962	-779,559	3,101,403	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,547,464	2,921,026	5,468,490	-1,442,685	4,025,805	-6,311	4,019,494	54
55	05500	RADIOLOGY-THERAPEUTIC	908,678	872,236	1,780,914	-334,514	1,446,400		1,446,400	55
56	05600	RADIOISOTOPE	231,792	808,169	1,039,961	-333,075	706,886		706,886	56
60	06000	LABORATORY	5,975,078	12,362,777	18,337,855	-729,846	17,608,009	-6,977,358	10,630,651	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	170,554	1,357,920	1,528,474	-144,505	1,383,969		1,383,969	63
65	06500	RESPIRATORY THERAPY	2,939,386	2,462,723	5,402,109	-593,084	4,809,025	-5,738	4,803,287	65
66	06600	PHYSICAL THERAPY	498,761	1,270,355	1,769,116	-11,409	1,757,707		1,757,707	66
69	06900	ELECTROCARDIOLOGY	1,139,884	768,045	1,907,929	-310,045	1,597,884	-46,848	1,551,036	69
70	07000	ELECTROENCEPHALOGRAPHY	67,525	56,323	123,848	-16,878	106,970		106,970	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		93	93	9,848,396	9,848,489		9,848,489	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				14,574,021	14,574,021		14,574,021	72
73	07300	DRUGS CHARGED TO PATIENTS				13,676,097	13,676,097		13,676,097	73
74	07400	RENAL DIALYSIS		727,981	727,981	-37,014	690,967		690,967	74
76	03340	GI LAB	361,741	673,363	1,035,104	-327,793	707,311		707,311	76
76.01	03450	MRI	483,919	820,506	1,304,425	-448,204	856,221		856,221	76.01
76.02	03290	CT SCAN	643,816	608,195	1,252,011	-200,809	1,051,202		1,051,202	76.02
76.03	03141	CARDIAC CATHETERIZATION	911,048	5,029,874	5,940,922	-4,370,584	1,570,338	-111,898	1,458,440	76.03
76.04	03950	PRIMARY PREVENTION PROGRAM								76.04
76.05	03951	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	03952	OUTPATIENT DETOX								76.07
76.08	03953	SPECIAL SURGICAL SERVICES	214,934	279,625	494,559	-24,780	469,779	-60,936	408,843	76.08
76.10	03955	GENETIC SERVICES	865,971	711,002	1,576,973	-241,185	1,335,788	-332,060	1,003,728	76.10
76.11	03140	CARDIOLOGY								76.11
76.12	03550	OUTPATIENT PSYCH SERVICES								76.12
76.97	07697	CARDIAC REHABILITATION								76.97

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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	
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09003	PAIN CENTER	648,990	419,239	1,068,229	-155,217	913,012		913,012	90.01
90.02	09001	ANTENATAL TEST CENTER	371,275	273,511	644,786	-25,805	618,981	-48,950	570,031	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	303,731	85,522	389,253	-4,384	384,869	-80	384,789	90.03
91	09100	EMERGENCY	5,148,151	4,281,788	9,429,939	-1,443,060	7,986,879	-120,007	7,866,872	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES	707,246	1,368,443	2,075,689	-24,374	2,051,315	-14,514	2,036,801	95
98	05950	AIR AMBULANCE								98
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES	127	1,442,795	1,442,922	-1,488	1,441,434		1,441,434	192
193.01	19301	BELOIT HEART STANDBY	46,975	13,113	60,088		60,088		60,088	193.01
194	07950	GUEST CENTER	64,743	251,312	316,055	-11,100	304,955	-75,791	229,164	194
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER								194.01
194.02	07951	COMMUNITY SERVICES	356,153	1,681,766	2,037,919	-27,144	2,010,775		2,010,775	194.02
194.04	07952	AUXILIARY	104,954	391,719	496,673	-2,100	494,573		494,573	194.04
194.07	07953	ROCKFORD HEALTH SYSTEM								194.07
194.08	07955	DIALYSIS RENTED SPACE								194.08
200		TOTAL (sum of lines 118-199)	107,916,966	188,926,633	296,843,599		296,843,599	-13,909,390	282,934,209	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS CHARGED TO PATIENTS	A	DRUGS CHARGED TO PATIENTS	73		13,676,097	1
500	TOTAL RECLASSIFICATIONS					13,676,097	500
	CODE LETTER - A						
1	EMT MEDICAL DIRECTOR	D	PARAMED EDUC EMT PROGRAM	23.02		30,000	1
500	TOTAL RECLASSIFICATIONS					30,000	500
	CODE LETTER - D						
1	SHARED DIETARY EXPENSES	E	CAFETERIA	11	1,505,292	2,342,258	1
500	TOTAL RECLASSIFICATIONS				1,505,292	2,342,258	500
	CODE LETTER - E						
1	RECLASS MED SUPPLIES CHGD PAT	F	MEDICAL SUPPLIES CHARGED TO P	71		9,848,396	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
500	TOTAL RECLASSIFICATIONS					9,848,396	500
	CODE LETTER - F						
1	NURSERY COSTS	G	NURSERY	43	703,996	392,593	1
2			NURSERY	43	1,018,630	572,663	2
500	TOTAL RECLASSIFICATIONS				1,722,626	965,256	500
	CODE LETTER - G						
1	DEPARTMENTAL DEPRECIATION	H	CAP REL COSTS-MVBLE EQUIP	2		14,124,964	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

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
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
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
500	TOTAL RECLASSIFICATIONS					14,124,964	500
	CODE LETTER - H						
1	INSURANCE RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		242,018	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					242,018	500
	CODE LETTER - I						
1	PASTORAL EDUCATION PROGRAM	J	PASTORAL EDUCATION PROGRAM	23.01	60,105	17,539	1
500	TOTAL RECLASSIFICATIONS				60,105	17,539	500
	CODE LETTER - J						
1	IMPLANTS	K	IMPL. DEV. CHARGED TO PATIENT	72		14,574,021	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					14,574,021	500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				3,288,023	55,820,549	

(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.

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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		13,676,097		1
500	TOTAL RECLASSIFICATIONS					13,676,097		500
	CODE LETTER - A							
1	EMT MEDICAL DIRECTOR	D	ADMINISTRATIVE & GENERAL	5		30,000		1
500	TOTAL RECLASSIFICATIONS					30,000		500
	CODE LETTER - D							
1	SHARED DIETARY EXPENSES	E	DIETARY	10	1,505,292	2,342,258		1
500	TOTAL RECLASSIFICATIONS				1,505,292	2,342,258		500
	CODE LETTER - E							
1	RECLASS MED SUPPLIES CHGD PAT	F	CENTRAL SERVICES & SUPPLY	14		683,734		1
2			ADULTS & PEDIATRICS	30		1,257,763		2
3			INTENSIVE CARE UNIT	31		469,424		3
4			NEONATAL INTENSIVE CARE	34.01		523,349		4
5			PEDIATRIC INTENSIVE CARE	34.02		63,099		5
6			SUBPROVIDER - IPF	40		6,956		6
7			OPERATING ROOM	50		3,508,153		7
8			RECOVERY ROOM	51		29,197		8
9			DELIVERY ROOM & LABOR ROOM	52		203,761		9
10			ANESTHESIOLOGY	53		40,358		10
11			RADIOLOGY-DIAGNOSTIC	54		444,831		11
12			RADIOLOGY-THERAPEUTIC	55		36,472		12
13			RADIOISOTOPE	56		293,857		13
14			BLOOD STORING, PROCESSING & T	63		116,939		14
15			RESPIRATORY THERAPY	65		340,258		15
16			PHYSICAL THERAPY	66		7,203		16
17			ELECTROCARDIOLOGY	69		25,778		17
18			ELECTROENCEPHALOGRAPHY	70		3,433		18
19			RENAL DIALYSIS	74		5,148		19
20			GI LAB	76		102,310		20
21			MRI	76.01		9,008		21
22			CT SCAN	76.02		108,106		22
23			CARDIAC CATHETERIZATION	76.03		451,840		23
24			SPECIAL SURGICAL SERVICES	76.08		10,611		24
25			GENETIC SERVICES	76.10		186,500		25
26			PAIN CENTER	90.01		112,268		26
27			ANTENATAL TEST CENTER	90.02		7,383		27
28			CHILD PSYCHIATRIC CLINIC	90.03		539		28
29			EMERGENCY	91		793,422		29
30			AMBULANCE SERVICES	95		4,729		30
31			PHYSICIANS' PRIVATE OFFICES	192		1,488		31
32			GUEST CENTER	194		39		32
33			COMMUNITY SERVICES	194.02		440		33
500	TOTAL RECLASSIFICATIONS					9,848,396		500
	CODE LETTER - F							
1	NURSERY COSTS	G	ADULTS & PEDIATRICS	30	703,996	392,593		1
2			NEONATAL INTENSIVE CARE	34.01	1,018,630	572,663		2
500	TOTAL RECLASSIFICATIONS				1,722,626	965,256		500
	CODE LETTER - G							
1	DEPARTMENTAL DEPRECIATION	H	EMPLOYEE BENEFITS DEPARTMENT	4		42,423	9	1
2			ADMINISTRATIVE & GENERAL	5		4,265,345		2
3			OPERATION OF PLANT	7		894,780		3
4			LAUNDRY & LINEN SERVICE	8		9,057		4
5			HOUSEKEEPING	9		25,050		5
6			DIETARY	10		71,431		6
7			NURSING ADMINISTRATION	13		15,155		7
8			CENTRAL SERVICES & SUPPLY	14		296,097		8
9			PHARMACY	15		435,568		9
10			MEDICAL RECORDS & LIBRARY	16		28,329		10
11			PARAMDICAL ED PROGRAM XRAY	23		90		11
12			PARAMED EDUC EMT PROGRAM	23.02		15,493		12
13			ADULTS & PEDIATRICS	30		1,360,889		13
14			INTENSIVE CARE UNIT	31		256,867		14
15			NEONATAL INTENSIVE CARE	34.01		235,936		15
16			PEDIATRIC INTENSIVE CARE	34.02		7,400		16
17			SUBPROVIDER - IPF	40		49,977		17

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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	
18			OPERATING ROOM	50		1,312,927		18
19			RECOVERY ROOM	51		8,149		19
20			DELIVERY ROOM & LABOR ROOM	52		259,597		20
21			ANESTHESIOLOGY	53		244,303		21
22			RADIOLOGY-DIAGNOSTIC	54		575,964		22
23			RADIOLOGY-THERAPEUTIC	55		298,042		23
24			RADIOISOTOPE	56		39,218		24
25			LABORATORY	60		729,206		25
26			BLOOD STORING, PROCESSING & T	63		27,566		26
27			RESPIRATORY THERAPY	65		252,826		27
28			PHYSICAL THERAPY	66		4,206		28
29			ELECTROCARDIOLOGY	69		284,267		29
30			ELECTROENCEPHALOGRAPHY	70		13,445		30
31			RENAL DIALYSIS	74		31,866		31
32			GI LAB	76		225,483		32
33			MRI	76.01		439,196		33
34			CT SCAN	76.02		92,703		34
35			CARDIAC CATHETERIZATION	76.03		434,031		35
36			SPECIAL SURGICAL SERVICES	76.08		14,169		36
37			GENETIC SERVICES	76.10		54,685		37
38			PAIN CENTER	90.01		42,949		38
39			ANTENATAL TEST CENTER	90.02		18,422		39
40			CHILD PSYCHIATRIC CLINIC	90.03		3,845		40
41			EMERGENCY	91		649,638		41
42			AMBULANCE SERVICES	95		19,645		42
43			GUEST CENTER	194		11,061		43
44			COMMUNITY SERVICES	194.02		25,568		44
45			AUXILIARY	194.04		2,100		45
500	TOTAL RECLASSIFICATIONS					14,124,964		500
	CODE LETTER - H							
1	INSURANCE RECLASS	I	ADMINISTRATIVE & GENERAL	5		240,242	12	1
2			LABORATORY	60		640		2
3			COMMUNITY SERVICES	194.02		1,136		3
500	TOTAL RECLASSIFICATIONS					242,018		500
	CODE LETTER - I							
1	PASTORAL EDUCATION PROGRAM	J	ADMINISTRATIVE & GENERAL	5	60,105	17,539		1
500	TOTAL RECLASSIFICATIONS				60,105	17,539		500
	CODE LETTER - J							
1	IMPLANTS	K	OPERATING ROOM	50		10,667,418		1
2			RADIOLOGY-DIAGNOSTIC	54		421,890		2
3			CARDIAC CATHETERIZATION	76.03		3,484,713		3
500	TOTAL RECLASSIFICATIONS					14,574,021		500
	CODE LETTER - K							
	GRAND TOTAL (DECREASES)				3,288,023	55,820,549		

(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.

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	1,079,662	3,731		3,731		1,083,393		1
2	LAND IMPROVEMENTS	6,918,755	58,916		58,916		6,977,671		2
3	BUILDINGS AND FIXTURES	54,645,292	395,029		395,029	480,144	54,560,177		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	106,738,445	3,913,480		3,913,480		110,651,925		5
6	MOVABLE EQUIPMENT	112,988,816	3,820,952		3,820,952	3,514,909	113,294,859		6
7	HIT DESIGNATED ASSETS	1,275,558	21,367,707		21,367,707		22,643,265		7
8	SUBTOTAL (sum of lines 1-7)	283,646,528	29,559,815		29,559,815	3,995,053	309,211,290		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	283,646,528	29,559,815		29,559,815	3,995,053	309,211,290		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	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	1,767,023						1,767,023	2
3	TOTAL (sum of lines 1-2)	1,767,023						1,767,023	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	-57,670			242,018			184,348	1
2	CAP REL COSTS-MVBLE EQUIP	15,889,616						15,889,616	2
3	TOTAL (sum of lines 1-2)	15,831,946			242,018			16,073,964	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.)

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
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)	B	-24,611	CENTRAL SERVICES & SUPPLY	14		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-4,789	OPERATION OF PLANT	7		8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-4,080,104				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	14,689,070				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,787,880	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	-24,632	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
33.01	XRAY COPY	B	-2,104	RADIOLOGY-DIAGNOSTIC	54		33.01
33.10	DAY CARE CENTER	B	-1,624,306	EMPLOYEE BENEFITS DEPARTMENT	4		33.10
33.17	MISC REVENUE - CYTOGENETICS	B	-276,680	GENETIC SERVICES	76.10		33.17
33.83	PATIENT PHONES	A	-16,029	EMPLOYEE BENEFITS DEPARTMENT	4		33.83
33.84	PATIENT PHONE COST	A	-90,967	ADMINISTRATIVE & GENERAL	5		33.84
33.88	PATIENT PHONES	A	-2,371	CAP REL COSTS-MVBLE EQUIP	2	9	33.88
33.89	AHA & IHA LOBBY EXPENSE	A	-11,929	ADMINISTRATIVE & GENERAL	5		33.89
34	USEFUL LIFE CHG-SO MULFORD	A	-57,670	CAP REL COSTS-BLDG & FIXT	1	9	34
34.03	INTEREST EXPENSE	A	-1,482,448	ADMINISTRATIVE & GENERAL	5		34.03
35	PHYSICIAN BILLING	A	-1,559	ADMINISTRATIVE & GENERAL	5		35
36	REFERENCE LABORATORY	B	-6,595,692	LABORATORY	60		36
37	PROVIDER TAX ASSESSMENT	A	-12,254,427	ADMINISTRATIVE & GENERAL	5		37
38							38
39							39
40							40
41	RENTAL REVENUE	B	-2,255	ADMINISTRATIVE & GENERAL	5		41
42	MISC REVENUE	B	-24,016	OPERATION OF PLANT	7		42
43							43
44	PASTORAL CARE	B	-4,225	PASTORAL EDUCATION PROGRAM	23.01		44
45	EDUCATION REV	B	-21,439	PARAMDICAL ED PROGRAM XRAY	23		45
45.17	EMS REV	B	-74,405	PARAMED EDUC EMT PROGRAM	23.02		45.17
45.18	MISC REV	B	-14,980	NEONATAL INTENSIVE CARE	34.01		45.18
45.26	MISC REV	B	-110	RESPIRATORY THERAPY	65		45.26
45.42	MISC REV	B	-80	CHILD PSYCHIATRIC CLINIC	90.03		45.42

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
45.43	MISC REV	B	-34,748	EMERGENCY	91		45.43
45.46	PROPERTY TAX	A	-75,791	GUEST CENTER	194		45.46
46	LEASE REVENUE	B	-8,213	AMBULANCE SERVICES	95		46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,909,390				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 ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	RHS MANAGEMENT FEE	19,478,980	4,621,481	14,857,499		1
2	50	OPERATING ROOM	RMB RENT	21,322	39,672	-18,350		2
3	54	RADIOLOGY-DIAGNOSTIC	RMB RENT	2,705	6,912	-4,207		3
3.01	60	LABORATORY	RMB RENT	24,902	18,540	6,362		3.01
3.02	65	RESPIRATORY THERAPY	RMB RENT	29,290	18,360	10,930		3.02
3.03	69	ELECTROCARDIOLOGY	RMB RENT		46,848	-46,848		3.03
3.04	76.08	SPECIAL SURGICAL SERVICES	RMB RENT		60,936	-60,936		3.04
3.05	76.10	GENETIC SERVICES	RMB RENT		55,380	-55,380		3.05
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			19,557,199	4,868,129	14,689,070		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.

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	E	RKFD MEM DVLMT			100.00	SERVICE	6
7	E	RMHSC				PHYSICIAN CLINI	7
8	E	FREEPORT MEM HO			50.00	MOBILE CATH LAB	8
9	B	ROCKFORD HEALTH SYSTEM				HOME OFFICE	9
10	B	VAN MATER REHAB HOSPITAL		VAN MATER REHAB HOSPITAL	50.00	REHAB HOSPITAL	10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	4	EMPLOYEE BENEFITS DE PROFESSIONAL FE	3,926	3,926		171,400				1
2	5	ADMINISTRATIVE & GEN PROFESSIONAL FE	2,215,341		2,215,341	171,400	10,330	851,232	42,562	2
4	13	NURSING ADMINISTRATI PROFESSIONAL FE	141,983	54,383	87,600	204,100	120	11,775	589	4
5	17	SOCIAL SERVICE PROFESSIONAL FE	92,400		92,400	154,100	1,155	85,570	4,279	5
6	30	ADULTS & PEDIATRICS PROFESSIONAL FE	77,250		77,250	154,100	140	10,372	519	6
7	31	INTENSIVE CARE UNIT PROFESSIONAL FE	613,109		613,109	171,400	8,828	727,461	36,373	7
8	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE	60,950		60,950	171,400	412	33,950	1,698	8
9	34.02	PEDIATRIC INTENSIVE PROFESSIONAL FE	25,357		25,357	171,400	175	14,421	721	9
10	40	SUBPROVIDER - IPF PROFESSIONAL FE	18,800	18,800						10
11	50	OPERATING ROOM PROFESSIONAL FE	1,674,632		1,674,632	204,100	7,247	711,112	35,556	11
13	52	DELIVERY ROOM & LABO PROFESSIONAL FE	904,806		904,806	194,500	9,127	853,462	42,673	13
14	53	ANESTHESIOLOGY PROFESSIONAL FE	1,652,694		1,652,694	200,300	9,067	873,135	43,657	14
16	60	LABORATORY PROFESSIONAL FE	388,028	388,028						16
17	65	RESPIRATORY THERAPY PROFESSIONAL FE	29,836		29,836	194,500	142	13,278	664	17
20	76.03	CARDIAC CATHETERIZAT PROFESSIONAL FE	111,898	111,898						20
22	90.02	ANTENATAL TEST CENTE PROFESSIONAL FE	48,950	48,950		241,000				22
23	91	EMERGENCY PROFESSIONAL FE	207,846		207,846	200,300	1,273	122,587	6,129	23
24	95	AMBULANCE SERVICES PROFESSIONAL FE	7,423		7,423	194,500	12	1,122	56	24
200		TOTAL	8,275,229	625,985	7,649,244		48,028	4,309,477	215,476	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW - ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	4	EMPLOYEE BENEFITS DE PROFESSIONAL FE							3,926	1
2	5	ADMINISTRATIVE & GEN PROFESSIONAL FE					851,232	1,364,109	1,364,109	2
4	13	NURSING ADMINISTRATI PROFESSIONAL FE					11,775	75,825	130,208	4
5	17	SOCIAL SERVICE PROFESSIONAL FE					85,570	6,830	6,830	5
6	30	ADULTS & PEDIATRICS PROFESSIONAL FE					10,372	66,878	66,878	6
7	31	INTENSIVE CARE UNIT PROFESSIONAL FE					727,461			7
8	34.01	NEONATAL INTENSIVE C PROFESSIONAL FE					33,950	27,000	27,000	8
9	34.02	PEDIATRIC INTENSIVE PROFESSIONAL FE					14,421	10,936	10,936	9
10	40	SUBPROVIDER - IPF PROFESSIONAL FE							18,800	10
11	50	OPERATING ROOM PROFESSIONAL FE					711,112	963,520	963,520	11
13	52	DELIVERY ROOM & LABO PROFESSIONAL FE					853,462	51,344	51,344	13
14	53	ANESTHESIOLOGY PROFESSIONAL FE					873,135	779,559	779,559	14
16	60	LABORATORY PROFESSIONAL FE							388,028	16
17	65	RESPIRATORY THERAPY PROFESSIONAL FE					13,278	16,558	16,558	17
20	76.03	CARDIAC CATHETERIZAT PROFESSIONAL FE							111,898	20
22	90.02	ANTENATAL TEST CENTE PROFESSIONAL FE							48,950	22
23	91	EMERGENCY PROFESSIONAL FE					122,587	85,259	85,259	23
24	95	AMBULANCE SERVICES PROFESSIONAL FE					1,122	6,301	6,301	24
200		TOTAL					4,309,477	3,454,119	4,080,104	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	184,348	184,348					1
2	CAP REL COSTS-MVBLE EQUIP	15,889,616		15,889,616				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,711,249	5,062	47,726	3,764,037			4
5	ADMINISTRATIVE & GENERAL	65,428,749	53,461	4,798,558	632,366	70,913,134	70,913,134	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,296,909	19,175	1,006,637	99,322	13,422,043	4,489,177	7
8	LAUNDRY & LINEN SERVICE	1,167,866	986	10,189	3,881	1,182,922	395,644	8
9	HOUSEKEEPING	3,373,186	2,153	28,182	71,266	3,474,787	1,162,188	9
10	DIETARY	1,510,660	1,488	80,361	25,355	1,617,864	541,116	10
11	CAFETERIA	2,059,670	6,620		53,740	2,120,030	709,072	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,587,315	1,488	17,050	92,489	3,698,342	1,236,959	13
14	CENTRAL SERVICES & SUPPLY	3,044,180	2,912	333,112	47,195	3,427,399	1,146,338	14
15	PHARMACY	5,367,133	1,679	490,019	134,754	5,993,585	2,004,632	15
16	MEDICAL RECORDS & LIBRARY	2,934,849	1,465	31,870	58,768	3,026,952	1,012,403	16
17	SOCIAL SERVICE	542,829	393		10,196	553,418	185,098	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	172,502	151	101	5,437	178,191	59,598	23
23.01	PASTORAL EDUCATION PROGRAM	73,419	201		2,146	75,766	25,341	23.01
23.02	PARAMED EDUC EMT PROGRAM	611,754	1,298	17,430	12,501	642,983	215,054	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	29,436,009	25,310	1,531,015	729,374	31,721,708	10,609,669	30
31	INTENSIVE CARE UNIT	8,286,423	2,254	288,978	139,545	8,717,200	2,915,581	31
34.01	NEONATAL INTENSIVE CARE	7,918,086	2,192	265,431	197,827	8,383,536	2,803,983	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,401,777	824	8,325	34,498	1,445,424	483,441	34.02
40	SUBPROVIDER - IPF	2,048,490	2,511	56,225	47,045	2,154,271	720,524	40
43	NURSERY	2,687,882	1,614		61,499	2,750,995	920,106	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,682,036	11,056	1,477,057	252,951	15,423,100	5,158,456	50
51	RECOVERY ROOM	1,384,808	780	9,168	35,674	1,430,430	478,426	51
52	DELIVERY ROOM & LABOR ROOM	4,341,803	3,167	292,049	86,007	4,723,026	1,579,677	52
53	ANESTHESIOLOGY	3,101,403	209	274,844	12,225	3,388,681	1,133,388	53
54	RADIOLOGY-DIAGNOSTIC	4,019,494	2,919	647,966	90,947	4,761,326	1,592,487	54
55	RADIOLOGY-THERAPEUTIC	1,446,400	2,550	335,301	32,441	1,816,692	607,616	55
56	RADIOISOTOPE	706,886	330	44,121	8,275	759,612	254,062	56
60	LABORATORY	10,630,651	4,646	820,365	213,316	11,668,978	3,902,841	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,383,969	169	31,012	6,089	1,421,239	475,352	63
65	RESPIRATORY THERAPY	4,803,287	2,495	284,432	104,939	5,195,153	1,737,586	65
66	PHYSICAL THERAPY	1,757,707	1,246	4,732	17,806	1,781,491	595,843	66
69	ELECTROCARDIOLOGY	1,551,036	1,925	319,804	40,695	1,913,460	639,982	69
70	ELECTROENCEPHALOGRAPHY	106,970	120	15,126	2,411	124,627	41,683	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,848,489				9,848,489	3,293,955	71
72	IMPL. DEV. CHARGED TO PATIENTS	14,574,021				14,574,021	4,874,471	72
73	DRUGS CHARGED TO PATIENTS	13,676,097				13,676,097	4,574,148	73
74	RENAL DIALYSIS	690,967	398	35,850		727,215	243,227	74
76	GI LAB	707,311	1,850	253,671	12,915	975,747	326,351	76
76.01	MRI	856,221	1,322	494,100	17,276	1,368,919	457,853	76.01
76.02	CT SCAN	1,051,202	670	104,292	22,985	1,179,149	394,382	76.02
76.03	CARDIAC CATHETERIZATION	1,458,440	1,261	488,290	32,525	1,980,516	662,409	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	408,843	800	15,940	7,673	433,256	144,908	76.08
76.10	GENETIC SERVICES	1,003,728	1,330	61,521	30,916	1,097,495	367,071	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	913,012	1,015	48,318	23,170	985,515	329,618	90.01
90.02	ANTENATAL TEST CENTER	570,031	1,223	20,725	13,255	605,234	202,428	90.02
90.03	CHILD PSYCHIATRIC CLINIC	384,789	385	4,326	10,844	400,344	133,900	90.03

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
91	EMERGENCY	7,866,872	4,152	730,850	183,794	8,785,668	2,938,481	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	2,036,801	1,370	20,976	25,249	2,084,396	697,153	95
98	AIR AMBULANCE							98
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)	278,698,175	180,625	15,846,045	3,743,582	278,630,426	69,473,678	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,441,434			5	1,441,439	482,108	192
193.01	BELOIT HEART STANDBY	60,088			1,677	61,765	20,658	193.01
194	GUEST CENTER	229,164	1,198	12,444	2,311	245,117	81,983	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	2,010,775	121	28,764	12,715	2,052,375	686,443	194.02
194.04	AUXILIARY	494,573	2,404	2,363	3,747	503,087	168,264	194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	282,934,209	184,348	15,889,616	3,764,037	282,934,209	70,913,134	202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	17,911,220						7
8	LAUNDRY & LINEN SERVICE	165,547	1,744,113					8
9	HOUSEKEEPING	361,594		4,998,569				9
10	DIETARY	249,971		71,876	2,480,827			10
11	CAFETERIA	1,111,782		319,679		4,260,563		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	249,971		71,876		119,281	5,376,429	13
14	CENTRAL SERVICES & SUPPLY	489,016	11,319	140,610		118,022		14
15	PHARMACY	282,004		81,087		138,660		15
16	MEDICAL RECORDS & LIBRARY	246,080		70,757		132,825		16
17	SOCIAL SERVICE	66,069		18,997		15,171		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	25,429		7,312		52,055		23
23.01	PASTORAL EDUCATION PROGRAM	33,762		9,708		36,147		23.01
23.02	PARAMED EDUC EMT PROGRAM	218,057		62,699		20,054	71,304	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,250,568	733,629	1,222,199	1,971,112	1,199,202	2,364,836	30
31	INTENSIVE CARE UNIT	378,533	74,147	108,842	233,472	192,097	378,828	31
34.01	NEONATAL INTENSIVE CARE	368,118	41,587	105,848		304,315	600,138	34.01
34.02	PEDIATRIC INTENSIVE CARE	138,349	4,074	39,780	48,043	40,538	79,919	34.02
40	SUBPROVIDER - IPF	421,767	16,931	121,274	173,486	70,912		40
43	NURSERY	271,077	11,454	77,945				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,856,822	261,379	533,905		305,421	602,267	50
51	RECOVERY ROOM	130,960	16,995	37,656		40,907	80,672	51
52	DELIVERY ROOM & LABOR ROOM	531,857	98,131	152,929		110,222	217,334	52
53	ANESTHESIOLOGY	35,098		10,092		18,488	36,477	53
54	RADIOLOGY-DIAGNOSTIC	490,156	57,645	140,938		131,596		54
55	RADIOLOGY-THERAPEUTIC	428,331	8,116	123,161		39,556		55
56	RADIOISOTOPE	55,379	59	15,923		9,213		56
60	LABORATORY	780,256	20,879	224,353		372,493		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	28,299		8,137		8,783		63
65	RESPIRATORY THERAPY	418,977	263	120,471		154,323		65
66	PHYSICAL THERAPY	209,174	1,156	60,145		21,006		66
69	ELECTROCARDIOLOGY	323,351		92,975		55,403	109,262	69
70	ELECTROENCEPHALOGRAPHY	20,123		5,786		4,115	17	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	66,777		19,201				74
76	GI LAB	310,735	21,800	89,348		17,628	34,763	76
76.01	MRI	222,066	12,978	63,852		25,552		76.01
76.02	CT SCAN	112,448		32,333		31,479		76.02
76.03	CARDIAC CATHETERIZATION	211,729	18,151	60,880		39,310	77,537	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	134,418	9,203	38,650		9,981	19,682	76.08
76.10	GENETIC SERVICES	223,284	158	64,202		37,467		76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	170,539		49,036		32,615	64,327	90.01
90.02	ANTENATAL TEST CENTER	205,362	10,250	59,049		16,584	32,686	90.02
90.03	CHILD PSYCHIATRIC CLINIC	64,694	553	18,602		9,889	19,502	90.03
91	EMERGENCY	697,247	305,754	200,484	54,714	268,629	529,720	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

KPMG LLP COMPU-MAX

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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	
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	230,162	318	66,180		28,991	57,158	95
98	AIR AMBULANCE							98
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)	17,285,938	1,736,929	4,818,777	2,480,827	4,228,930	5,376,429	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER	201,156	7,184	57,840		4,607		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	20,320		5,843		17,260		194.02
194.04	AUXILIARY	403,806		116,109		9,766		194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	17,911,220	1,744,113	4,998,569	2,480,827	4,260,563	5,376,429	202

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COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDIC A EDUCATION XRAY		
		14	15	16	17	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	5,332,704						14
15	PHARMACY		8,499,968					15
16	MEDICAL RECORDS & LIBRARY			4,489,017				16
17	SOCIAL SERVICE				838,753			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					322,585		23
23.01	PASTORAL EDUCATION PROGRAM						180,724	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			296,891	714,350		118,994	30
31	INTENSIVE CARE UNIT			77,735			13,579	31
34.01	NEONATAL INTENSIVE CARE			199,853	10,939		30,246	34.01
34.02	PEDIATRIC INTENSIVE CARE			20,054	3,110		3,144	34.02
40	SUBPROVIDER - IPF			25,172	104,241		7,591	40
43	NURSERY			37,897	6,113		7,170	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			304,434				50
51	RECOVERY ROOM			30,303				51
52	DELIVERY ROOM & LABOR ROOM			63,645				52
53	ANESTHESIOLOGY		113,935	56,385				53
54	RADIOLOGY-DIAGNOSTIC			179,243		322,585		54
55	RADIOLOGY-THERAPEUTIC			59,560				55
56	RADIOISOTOPE			38,868				56
60	LABORATORY			315,293				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.			53,041				63
65	RESPIRATORY THERAPY			171,751				65
66	PHYSICAL THERAPY			31,024				66
69	ELECTROCARDIOLOGY			127,236				69
70	ELECTROENCEPHALOGRAPHY			7,815				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,150,427		642,939				71
72	IMPL. DEV. CHARGED TO PATIENTS	3,182,277		404,917				72
73	DRUGS CHARGED TO PATIENTS		8,386,033	546,218				73
74	RENAL DIALYSIS			7,130				74
76	GI LAB			22,828				76
76.01	MRI			115,257				76.01
76.02	CT SCAN			219,385				76.02
76.03	CARDIAC CATHETERIZATION			87,778				76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES			11,185				76.08
76.10	GENETIC SERVICES			4,507				76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER			31,723				90.01
90.02	ANTENATAL TEST CENTER			29,994				90.02
90.03	CHILD PSYCHIATRIC CLINIC			1,572				90.03
91	EMERGENCY			253,609				91

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDIC A EDUCATION XRAY		
		14	15	16	17	23	23.01	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES			13,775				95
98	AIR AMBULANCE							98
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)	5,332,704	8,499,968	4,489,017	838,753	322,585	180,724	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
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	5,332,704	8,499,968	4,489,017	838,753	322,585	180,724	202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23.02	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY							23
23.01	PASTORAL EDUCATION PROGRAM							23.01
23.02	PARAMED EDUC EMT PROGRAM	1,230,151						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	32,676	55,235,834		55,235,834			30
31	INTENSIVE CARE UNIT	65,352	13,155,366		13,155,366			31
34.01	NEONATAL INTENSIVE CARE		12,848,563		12,848,563			34.01
34.02	PEDIATRIC INTENSIVE CARE		2,305,876		2,305,876			34.02
40	SUBPROVIDER - IPF		3,816,169		3,816,169			40
43	NURSERY		4,082,757		4,082,757			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	171,068	24,616,852		24,616,852			50
51	RECOVERY ROOM		2,246,349		2,246,349			51
52	DELIVERY ROOM & LABOR ROOM	32,676	7,509,497		7,509,497			52
53	ANESTHESIOLOGY		4,792,544		4,792,544			53
54	RADIOLOGY-DIAGNOSTIC		7,675,976		7,675,976			54
55	RADIOLOGY-THERAPEUTIC		3,083,032		3,083,032			55
56	RADIOISOTOPE		1,133,116		1,133,116			56
60	LABORATORY		17,285,093		17,285,093			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		1,994,851		1,994,851			63
65	RESPIRATORY THERAPY	24,987	7,823,511		7,823,511			65
66	PHYSICAL THERAPY		2,699,839		2,699,839			66
69	ELECTROCARDIOLOGY		3,261,669		3,261,669			69
70	ELECTROENCEPHALOGRAPHY		204,166		204,166			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		15,935,810		15,935,810			71
72	IMPL. DEV. CHARGED TO PATIENTS		23,035,686		23,035,686			72
73	DRUGS CHARGED TO PATIENTS		27,182,496		27,182,496			73
74	RENAL DIALYSIS		1,063,550		1,063,550			74
76	GI LAB		1,799,200		1,799,200			76
76.01	MRI		2,266,477		2,266,477			76.01
76.02	CT SCAN		1,969,176		1,969,176			76.02
76.03	CARDIAC CATHETERIZATION		3,138,310		3,138,310			76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES		801,283		801,283			76.08
76.10	GENETIC SERVICES		1,794,184		1,794,184			76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		1,663,373		1,663,373			90.01
90.02	ANTENATAL TEST CENTER		1,161,587		1,161,587			90.02
90.03	CHILD PSYCHIATRIC CLINIC		649,056		649,056			90.03
91	EMERGENCY	903,392	14,937,698		14,937,698			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23.02	24	25	26			
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		3,178,133		3,178,133			95
98	AIR AMBULANCE							98
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)	1,230,151	276,347,079		276,347,079			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		1,923,547		1,923,547			192
193.01	BELOIT HEART STANDBY		82,423		82,423			193.01
194	GUEST CENTER		597,887		597,887			194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES		2,782,241		2,782,241			194.02
194.04	AUXILIARY		1,201,032		1,201,032			194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,230,151	282,934,209		282,934,209			202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	12,607	5,062	47,726	65,395	65,395		4
5	ADMINISTRATIVE & GENERAL	173,388	53,461	4,798,558	5,025,407	10,982	5,036,389	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	21,006	19,175	1,006,637	1,046,818	1,725	318,827	7
8	LAUNDRY & LINEN SERVICE		986	10,189	11,175	67	28,099	8
9	HOUSEKEEPING	12,095	2,153	28,182	42,430	1,238	82,540	9
10	DIETARY	1,017	1,488	80,361	82,866	440	38,431	10
11	CAFETERIA		6,620		6,620	933	50,359	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	14,098	1,488	17,050	32,636	1,606	87,850	13
14	CENTRAL SERVICES & SUPPLY	471,607	2,912	333,112	807,631	820	81,414	14
15	PHARMACY	28,822	1,679	490,019	520,520	2,340	142,372	15
16	MEDICAL RECORDS & LIBRARY	13,078	1,465	31,870	46,413	1,021	71,902	16
17	SOCIAL SERVICE	1,305	393		1,698	177	13,146	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	4,501	151	101	4,753	94	4,233	23
23.01	PASTORAL EDUCATION PROGRAM		201		201	37	1,800	23.01
23.02	PARAMED EDUC EMT PROGRAM	14,700	1,298	17,430	33,428	217	15,273	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	115,523	25,310	1,531,015	1,671,848	12,696	753,556	30
31	INTENSIVE CARE UNIT	13,688	2,254	288,978	304,920	2,423	207,068	31
34.01	NEONATAL INTENSIVE CARE	21,633	2,192	265,431	289,256	3,436	199,143	34.01
34.02	PEDIATRIC INTENSIVE CARE	6,195	824	8,325	15,344	599	34,335	34.02
40	SUBPROVIDER - IPF	5,491	2,511	56,225	64,227	817	51,173	40
43	NURSERY		1,614		1,614	1,068	65,347	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	276,706	11,056	1,477,057	1,764,819	4,393	366,360	50
51	RECOVERY ROOM	3,934	780	9,168	13,882	620	33,978	51
52	DELIVERY ROOM & LABOR ROOM	12,231	3,167	292,049	307,447	1,494	112,191	52
53	ANESTHESIOLOGY	4,201	209	274,844	279,254	212	80,495	53
54	RADIOLOGY-DIAGNOSTIC	33,562	2,919	647,966	684,447	1,579	113,101	54
55	RADIOLOGY-THERAPEUTIC	9,158	2,550	335,301	347,009	563	43,154	55
56	RADIOISOTOPE	135	330	44,121	44,586	144	18,044	56
60	LABORATORY	27,534	4,646	820,365	852,545	3,705	277,185	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,671	169	31,012	33,852	106	33,760	63
65	RESPIRATORY THERAPY	32,235	2,495	284,432	319,162	1,822	123,406	65
66	PHYSICAL THERAPY	6,928	1,246	4,732	12,906	309	42,318	66
69	ELECTROCARDIOLOGY	12,383	1,925	319,804	334,112	707	45,452	69
70	ELECTROENCEPHALOGRAPHY		120	15,126	15,246	42	2,960	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						233,941	71
72	IMPL. DEV. CHARGED TO PATIENTS						346,191	72
73	DRUGS CHARGED TO PATIENTS						324,862	73
74	RENAL DIALYSIS	55	398	35,850	36,303		17,274	74
76	GI LAB	478	1,850	253,671	255,999	224	23,178	76
76.01	MRI	420	1,322	494,100	495,842	300	32,517	76.01
76.02	CT SCAN	558	670	104,292	105,520	399	28,010	76.02
76.03	CARDIAC CATHETERIZATION	11,290	1,261	488,290	500,841	565	47,045	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	1,652	800	15,940	18,392	133	10,292	76.08
76.10	GENETIC SERVICES	4,627	1,330	61,521	67,478	537	26,070	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	9,776	1,015	48,318	59,109	402	23,410	90.01
90.02	ANTENATAL TEST CENTER	1,132	1,223	20,725	23,080	230	14,377	90.02
90.03	CHILD PSYCHIATRIC CLINIC	516	385	4,326	5,227	188	9,510	90.03
91	EMERGENCY	16,683	4,152	730,850	751,685	3,192	208,695	91

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	2,918	1,370	20,976	25,264	438	49,513	95
98	AIR AMBULANCE							98
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)	1,402,537	180,625	15,846,045	17,429,207	65,040	4,934,157	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	302			302		34,240	192
193.01	BELOIT HEART STANDBY					29	1,467	193.01
194	GUEST CENTER		1,198	12,444	13,642	40	5,823	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	1,488	121	28,764	30,373	221	48,752	194.02
194.04	AUXILIARY	383	2,404	2,363	5,150	65	11,950	194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,404,710	184,348	15,889,616	17,478,674	65,395	5,036,389	202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
	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	1,367,370						7
8	LAUNDRY & LINEN SERVICE	12,638	51,979					8
9	HOUSEKEEPING	27,605		153,813				9
10	DIETARY	19,083		2,212	143,032			10
11	CAFETERIA	84,875		9,837		152,624		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	19,083		2,212		4,273	147,660	13
14	CENTRAL SERVICES & SUPPLY	37,332	337	4,327		4,228		14
15	PHARMACY	21,529		2,495		4,967		15
16	MEDICAL RECORDS & LIBRARY	18,786		2,177		4,758		16
17	SOCIAL SERVICE	5,044		585		543		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY	1,941		225		1,865		23
23.01	PASTORAL EDUCATION PROGRAM	2,577		299		1,295		23.01
23.02	PARAMED EDUC EMT PROGRAM	16,647		1,929		718	1,958	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	324,495	21,866	37,608	113,644	42,962	64,947	30
31	INTENSIVE CARE UNIT	28,898	2,210	3,349	13,461	6,881	10,404	31
34.01	NEONATAL INTENSIVE CARE	28,103	1,239	3,257		10,901	16,482	34.01
34.02	PEDIATRIC INTENSIVE CARE	10,562	121	1,224	2,770	1,452	2,195	34.02
40	SUBPROVIDER - IPF	32,198	505	3,732	10,002	2,540		40
43	NURSERY	20,694	341	2,398				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	141,753	7,790	16,429		10,941	16,541	50
51	RECOVERY ROOM	9,998	506	1,159		1,465	2,216	51
52	DELIVERY ROOM & LABOR ROOM	40,603	2,925	4,706		3,948	5,969	52
53	ANESTHESIOLOGY	2,679		311		662	1,002	53
54	RADIOLOGY-DIAGNOSTIC	37,419	1,718	4,337		4,714		54
55	RADIOLOGY-THERAPEUTIC	32,699	242	3,790		1,417		55
56	RADIOISOTOPE	4,228	2	490		330		56
60	LABORATORY	59,566	622	6,904		13,344		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,160		250		315		63
65	RESPIRATORY THERAPY	31,985	8	3,707		5,528		65
66	PHYSICAL THERAPY	15,969	34	1,851		752		66
69	ELECTROCARDIOLOGY	24,685		2,861		1,985	3,001	69
70	ELECTROENCEPHALOGRAPHY	1,536		178		147		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	5,098		591				74
76	GI LAB	23,722	650	2,749		631	955	76
76.01	MRI	16,953	387	1,965		915		76.01
76.02	CT SCAN	8,584		995		1,128		76.02
76.03	CARDIAC CATHETERIZATION	16,164	541	1,873		1,408	2,130	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	10,262	274	1,189		358	541	76.08
76.10	GENETIC SERVICES	17,046	5	1,976		1,342		76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	13,019		1,509		1,168	1,767	90.01
90.02	ANTENATAL TEST CENTER	15,678	305	1,817		594	898	90.02
90.03	CHILD PSYCHIATRIC CLINIC	4,939	16	572		354	536	90.03
91	EMERGENCY	53,229	9,112	6,169	3,155	9,623	14,548	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	17,571	9	2,036		1,039	1,570	95
98	AIR AMBULANCE							98
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)	1,319,635	51,765	148,280	143,032	151,491	147,660	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER	15,357	214	1,780		165		194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	1,551		180		618		194.02
194.04	AUXILIARY	30,827		3,573		350		194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,367,370	51,979	153,813	143,032	152,624	147,660	202

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDIC A EDUCATION XRAY		
		14	15	16	17	23	23.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	936,089						14
15	PHARMACY		694,223					15
16	MEDICAL RECORDS & LIBRARY			145,057				16
17	SOCIAL SERVICE				21,193			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					13,111		23
23.01	PASTORAL EDUCATION PROGRAM						6,209	23.01
23.02	PARAMED EDUC EMT PROGRAM							23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			9,571	18,050			30
31	INTENSIVE CARE UNIT			2,506				31
34.01	NEONATAL INTENSIVE CARE			6,443	276			34.01
34.02	PEDIATRIC INTENSIVE CARE			647	79			34.02
40	SUBPROVIDER - IPF			812	2,634			40
43	NURSERY			1,222	154			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			9,815				50
51	RECOVERY ROOM			977				51
52	DELIVERY ROOM & LABOR ROOM			2,052				52
53	ANESTHESIOLOGY		9,305	1,818				53
54	RADIOLOGY-DIAGNOSTIC			5,779				54
55	RADIOLOGY-THERAPEUTIC			1,920				55
56	RADIOISOTOPE			1,253				56
60	LABORATORY			10,165				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.			1,710				63
65	RESPIRATORY THERAPY			5,537				65
66	PHYSICAL THERAPY			1,000				66
69	ELECTROCARDIOLOGY			4,102				69
70	ELECTROENCEPHALOGRAPHY			252				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	377,479		21,061				71
72	IMPL. DEV. CHARGED TO PATIENTS	558,610		13,054				72
73	DRUGS CHARGED TO PATIENTS		684,918	17,609				73
74	RENAL DIALYSIS			230				74
76	GI LAB			736				76
76.01	MRI			3,716				76.01
76.02	CT SCAN			7,073				76.02
76.03	CARDIAC CATHETERIZATION			2,830				76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES			361				76.08
76.10	GENETIC SERVICES			145				76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER			1,023				90.01
90.02	ANTENATAL TEST CENTER			967				90.02
90.03	CHILD PSYCHIATRIC CLINIC			51				90.03
91	EMERGENCY			8,176				91

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	PARAMEDIC A EDUCATION XRAY		
		14	15	16	17	23	23.01	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES			444				95
98	AIR AMBULANCE							98
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)	936,089	694,223	145,057	21,193			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
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS					13,111	6,209	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	936,089	694,223	145,057	21,193	13,111	6,209	202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23.02	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY							23
23.01	PASTORAL EDUCATION PROGRAM							23.01
23.02	PARAMED EDUC EMT PROGRAM	70,170						23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		3,071,243		3,071,243			30
31	INTENSIVE CARE UNIT		582,120		582,120			31
34.01	NEONATAL INTENSIVE CARE		558,536		558,536			34.01
34.02	PEDIATRIC INTENSIVE CARE		69,328		69,328			34.02
40	SUBPROVIDER - IPF		168,640		168,640			40
43	NURSERY		92,838		92,838			43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		2,338,841		2,338,841			50
51	RECOVERY ROOM		64,801		64,801			51
52	DELIVERY ROOM & LABOR ROOM		481,335		481,335			52
53	ANESTHESIOLOGY		375,738		375,738			53
54	RADIOLOGY-DIAGNOSTIC		853,094		853,094			54
55	RADIOLOGY-THERAPEUTIC		430,794		430,794			55
56	RADIOISOTOPE		69,077		69,077			56
60	LABORATORY		1,224,036		1,224,036			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		72,153		72,153			63
65	RESPIRATORY THERAPY		491,155		491,155			65
66	PHYSICAL THERAPY		75,139		75,139			66
69	ELECTROCARDIOLOGY		416,905		416,905			69
70	ELECTROENCEPHALOGRAPHY		20,361		20,361			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		632,481		632,481			71
72	IMPL. DEV. CHARGED TO PATIENTS		917,855		917,855			72
73	DRUGS CHARGED TO PATIENTS		1,027,389		1,027,389			73
74	RENAL DIALYSIS		59,496		59,496			74
76	GI LAB		308,844		308,844			76
76.01	MRI		552,595		552,595			76.01
76.02	CT SCAN		151,709		151,709			76.02
76.03	CARDIAC CATHETERIZATION		573,397		573,397			76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES		41,802		41,802			76.08
76.10	GENETIC SERVICES		114,599		114,599			76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		101,407		101,407			90.01
90.02	ANTENATAL TEST CENTER		57,946		57,946			90.02
90.03	CHILD PSYCHIATRIC CLINIC		21,393		21,393			90.03
91	EMERGENCY		1,067,584		1,067,584			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PARA MED EDUC EMT	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		23.02	24	25	26			
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		97,884		97,884			95
98	AIR AMBULANCE							98
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)		17,182,515		17,182,515			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		34,542		34,542			192
193.01	BELOIT HEART STANDBY		1,496		1,496			193.01
194	GUEST CENTER		37,021		37,021			194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES		81,695		81,695			194.02
194.04	AUXILIARY		51,915		51,915			194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS	70,170	89,490		89,490			200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	70,170	17,478,674		17,478,674			202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	787,716						1
2	CAP REL COSTS-MVBLE EQUIP		14,123,964					2
4	EMPLOYEE BENEFITS DEPARTMENT	21,631	42,423	105,432,287				4
5	ADMINISTRATIVE & GENERAL	228,435	4,265,345	17,712,826	-70,913,134	212,021,075		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	81,936	894,780	2,782,056		13,422,043	455,714	7
8	LAUNDRY & LINEN SERVICE	4,212	9,057	108,722		1,182,922	4,212	8
9	HOUSEKEEPING	9,200	25,050	1,996,189		3,474,787	9,200	9
10	DIETARY	6,360	71,431	710,216		1,617,864	6,360	10
11	CAFETERIA	28,287		1,505,292		2,120,030	28,287	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,360	15,155	2,590,666		3,698,342	6,360	13
14	CENTRAL SERVICES & SUPPLY	12,442	296,097	1,321,954		3,427,399	12,442	14
15	PHARMACY	7,175	435,568	3,774,515		5,993,585	7,175	15
16	MEDICAL RECORDS & LIBRARY	6,261	28,329	1,646,109		3,026,952	6,261	16
17	SOCIAL SERVICE	1,681		285,594		553,418	1,681	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY	647	90	152,288		178,191	647	23
23.01	PASTORAL EDUCATION PROGRAM	859		60,105		75,766	859	23.01
23.02	PARAMED EDUC EMT PROGRAM	5,548	15,493	350,172		642,983	5,548	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	108,147	1,360,889	20,430,019		31,721,708	108,147	30
31	INTENSIVE CARE UNIT	9,631	256,867	3,908,724		8,717,200	9,631	31
34.01	NEONATAL INTENSIVE CARE	9,366	235,936	5,541,220		8,383,536	9,366	34.01
34.02	PEDIATRIC INTENSIVE CARE	3,520	7,400	966,315		1,445,424	3,520	34.02
40	SUBPROVIDER - IPF	10,731	49,977	1,317,743		2,154,271	10,731	40
43	NURSERY	6,897		1,722,626		2,750,995	6,897	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	47,243	1,312,927	7,085,260		15,423,100	47,243	50
51	RECOVERY ROOM	3,332	8,149	999,257		1,430,430	3,332	51
52	DELIVERY ROOM & LABOR ROOM	13,532	259,597	2,409,087		4,723,026	13,532	52
53	ANESTHESIOLOGY	893	244,303	342,436		3,388,681	893	53
54	RADIOLOGY-DIAGNOSTIC	12,471	575,964	2,547,464		4,761,326	12,471	54
55	RADIOLOGY-THERAPEUTIC	10,898	298,042	908,678		1,816,692	10,898	55
56	RADIOISOTOPE	1,409	39,218	231,792		759,612	1,409	56
60	LABORATORY	19,852	729,206	5,975,078		11,668,978	19,852	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	720	27,566	170,554		1,421,239	720	63
65	RESPIRATORY THERAPY	10,660	252,826	2,939,386		5,195,153	10,660	65
66	PHYSICAL THERAPY	5,322	4,206	498,761		1,781,491	5,322	66
69	ELECTROCARDIOLOGY	8,227	284,267	1,139,884		1,913,460	8,227	69
70	ELECTROENCEPHALOGRAPHY	512	13,445	67,525		124,627	512	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					9,848,489		71
72	IMPL. DEV. CHARGED TO PATIENTS					14,574,021		72
73	DRUGS CHARGED TO PATIENTS					13,676,097		73
74	RENAL DIALYSIS	1,699	31,866			727,215	1,699	74
76	GI LAB	7,906	225,483	361,741		975,747	7,906	76
76.01	MRI	5,650	439,196	483,919		1,368,919	5,650	76.01
76.02	CT SCAN	2,861	92,703	643,816		1,179,149	2,861	76.02
76.03	CARDIAC CATHETERIZATION	5,387	434,031	911,048		1,980,516	5,387	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	3,420	14,169	214,934		433,256	3,420	76.08
76.10	GENETIC SERVICES	5,681	54,685	865,971		1,097,495	5,681	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	4,339	42,949	648,990		985,515	4,339	90.01
90.02	ANTENATAL TEST CENTER	5,225	18,422	371,275		605,234	5,225	90.02
90.03	CHILD PSYCHIATRIC CLINIC	1,646	3,845	303,731		400,344	1,646	90.03

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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	
91	EMERGENCY	17,740	649,638	5,148,151		8,785,668	17,740	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	5,856	18,645	707,246		2,084,396	5,856	95
98	AIR AMBULANCE							98
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)	771,807	14,085,235	104,859,335	-70,913,134	207,717,292	439,805	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			127		1,441,439		192
193.01	BELOIT HEART STANDBY			46,975		61,765		193.01
194	GUEST CENTER	5,118	11,061	64,743		245,117	5,118	194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES	517	25,568	356,153		2,052,375	517	194.02
194.04	AUXILIARY	10,274	2,100	104,954		503,087	10,274	194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	184,348	15,889,616	3,764,037		70,913,134	17,911,220	202
203	UNIT COST MULT-WS B PT I	0.234029	1.125011	0.035701		0.334463	39.303642	203
204	COST TO BE ALLOC PER B PT II			65,395		5,036,389	1,367,370	204
205	UNIT COST MULT-WS B PT II			0.000620		0.023754	3.000500	205

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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 ADMINIS-TRATION 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	763,328						8
9	HOUSEKEEPING		442,302					9
10	DIETARY		6,360	202,315				10
11	CAFETERIA		28,287		138,731			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		6,360		3,884	1,850,958		13
14	CENTRAL SERVICES & SUPPLY	4,954	12,442		3,843		24,422,417	14
15	PHARMACY		7,175		4,515			15
16	MEDICAL RECORDS & LIBRARY		6,261		4,325			16
17	SOCIAL SERVICE		1,681		494			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY		647		1,695			23
23.01	PASTORAL EDUCATION PROGRAM		859		1,177			23.01
23.02	PARAMED EDUC EMT PROGRAM		5,548		653	24,548		23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	321,080	108,147	160,747	39,048	814,149		30
31	INTENSIVE CARE UNIT	32,451	9,631	19,040	6,255	130,420		31
34.01	NEONATAL INTENSIVE CARE	18,201	9,366		9,909	206,611		34.01
34.02	PEDIATRIC INTENSIVE CARE	1,783	3,520	3,918	1,320	27,514		34.02
40	SUBPROVIDER - IPF	7,410	10,731	14,148	2,309			40
43	NURSERY	5,013	6,897					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	114,395	47,243		9,945	207,344		50
51	RECOVERY ROOM	7,438	3,332		1,332	27,773		51
52	DELIVERY ROOM & LABOR ROOM	42,948	13,532		3,589	74,822		52
53	ANESTHESIOLOGY		893		602	12,558		53
54	RADIOLOGY-DIAGNOSTIC	25,229	12,471		4,285			54
55	RADIOLOGY-THERAPEUTIC	3,552	10,898		1,288			55
56	RADIOISOTOPE	26	1,409		300			56
60	LABORATORY	9,138	19,852		12,129			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		720		286			63
65	RESPIRATORY THERAPY	115	10,660		5,025			65
66	PHYSICAL THERAPY	506	5,322		684			66
69	ELECTROCARDIOLOGY		8,227		1,804	37,616		69
70	ELECTROENCEPHALOGRAPHY		512		134	6		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						9,848,396	71
72	IMPL. DEV. CHARGED TO PATIENTS						14,574,021	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		1,699					74
76	GI LAB	9,541	7,906		574	11,968		76
76.01	MRI	5,680	5,650		832			76.01
76.02	CT SCAN		2,861		1,025			76.02
76.03	CARDIAC CATHETERIZATION	7,944	5,387		1,280	26,694		76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	4,028	3,420		325	6,776		76.08
76.10	GENETIC SERVICES	69	5,681		1,220			76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		4,339		1,062	22,146		90.01
90.02	ANTENATAL TEST CENTER	4,486	5,225		540	11,253		90.02
90.03	CHILD PSYCHIATRIC CLINIC	242	1,646		322	6,714		90.03
91	EMERGENCY	133,816	17,740	4,462	8,747	182,368		91

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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 ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	139	5,856		944	19,678		95
98	AIR AMBULANCE							98
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)	760,184	426,393	202,315	137,701	1,850,958	24,422,417	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
193.01	BELOIT HEART STANDBY							193.01
194	GUEST CENTER	3,144	5,118		150			194
194.01	OTHER NONREIMBURSEABLE COST CENTER							194.01
194.02	COMMUNITY SERVICES		517		562			194.02
194.04	AUXILIARY		10,274		318			194.04
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,744,113	4,998,569	2,480,827	4,260,563	5,376,429	5,332,704	202
203	UNIT COST MULT-WS B PT I	2.284880	11.301258	12.262200	30.710966	2.904674	0.218353	203
204	COST TO BE ALLOC PER B PT II	51,979	153,813	143,032	152,624	147,660	936,089	204
205	UNIT COST MULT-WS B PT II	0.068095	0.347756	0.706977	1.100143	0.079775	0.038329	205

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE VISITS	PARAMEDICA EDUCATION XRAY ASSIGNED TIME		PARA MED EDUC EMT TIME SPENT	
		15	16	17	23	23.01	23.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	13,861,905						15
16	MEDICAL RECORDS & LIBRARY		887,808,426					16
17	SOCIAL SERVICE			7,821				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMDICAL ED PROGRAM XRAY				100			23
23.01	PASTORAL EDUCATION PROGRAM					73,800		23.01
23.02	PARAMED EDUC EMT PROGRAM						640	23.02
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		58,720,482	6,661		48,592	17	30
31	INTENSIVE CARE UNIT		15,374,850			5,545	34	31
34.01	NEONATAL INTENSIVE CARE		39,527,806	102		12,351		34.01
34.02	PEDIATRIC INTENSIVE CARE		3,966,429	29		1,284		34.02
40	SUBPROVIDER - IPF		4,978,735	972		3,100		40
43	NURSERY		7,495,518	57		2,928		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		60,212,331				89	50
51	RECOVERY ROOM		5,993,377					51
52	DELIVERY ROOM & LABOR ROOM		12,587,963				17	52
53	ANESTHESIOLOGY	185,808	11,152,148					53
54	RADIOLOGY-DIAGNOSTIC		35,451,508		100			54
55	RADIOLOGY-THERAPEUTIC		11,780,042					55
56	RADIOISOTOPE		7,687,419					56
60	LABORATORY		62,360,119					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		10,490,803					63
65	RESPIRATORY THERAPY		33,969,799				13	65
66	PHYSICAL THERAPY		6,136,172					66
69	ELECTROCARDIOLOGY		25,165,422					69
70	ELECTROENCEPHALOGRAPHY		1,545,702					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		127,112,579					71
72	IMPL. DEV. CHARGED TO PATIENTS		80,086,465					72
73	DRUGS CHARGED TO PATIENTS	13,676,097	108,033,590					73
74	RENAL DIALYSIS		1,410,215					74
76	GI LAB		4,514,976					76
76.01	MRI		22,796,104					76.01
76.02	CT SCAN		43,391,000					76.02
76.03	CARDIAC CATHETERIZATION		17,361,229					76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES		2,212,150					76.08
76.10	GENETIC SERVICES		891,320					76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER		6,274,291					90.01

KPMG LLP COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE VISITS	PARAMEDICA EDUCATION XRAY ASSIGNED TIME		PARA MED EDUC EMT TIME SPENT	
		15	16	17	23	23.01	23.02	
90.02	ANTENATAL TEST CENTER		5,932,404					90.02
90.03	CHILD PSYCHIATRIC CLINIC		310,959					90.03
91	EMERGENCY		50,159,972				470	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		2,724,547					95
98	AIR AMBULANCE							98
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)	13,861,905	887,808,426	7,821	100	73,800	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
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	8,499,968	4,489,017	838,753	322,585	180,724	1,230,151	202
203	UNIT COST MULT-WS B PT I	0.613189	0.005056	107.243703	3,225.850000	2.448835	1,922.110938	203
204	COST TO BE ALLOC PER B PT II	694,223	145,057	21,193	13,111	6,209	70,170	204
205	UNIT COST MULT-WS B PT II	0.050081	0.000163	2.709756	131.110000	0.084133	109.640625	205

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	55,235,834		55,235,834	66,878	55,302,712	30
31	INTENSIVE CARE UNIT	13,155,366		13,155,366		13,155,366	31
34.01	NEONATAL INTENSIVE CARE	12,848,563		12,848,563	27,000	12,875,563	34.01
34.02	PEDIATRIC INTENSIVE CARE	2,305,876		2,305,876	10,936	2,316,812	34.02
40	SUBPROVIDER - IPF	3,816,169		3,816,169		3,816,169	40
43	NURSERY	4,082,757		4,082,757		4,082,757	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	24,616,852		24,616,852	963,520	25,580,372	50
51	RECOVERY ROOM	2,246,349		2,246,349		2,246,349	51
52	DELIVERY ROOM & LABOR ROOM	7,509,497		7,509,497	51,344	7,560,841	52
53	ANESTHESIOLOGY	4,792,544		4,792,544	779,559	5,572,103	53
54	RADIOLOGY-DIAGNOSTIC	7,675,976		7,675,976		7,675,976	54
55	RADIOLOGY-THERAPEUTIC	3,083,032		3,083,032		3,083,032	55
56	RADIOISOTOPE	1,133,116		1,133,116		1,133,116	56
60	LABORATORY	17,285,093		17,285,093		17,285,093	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,994,851		1,994,851		1,994,851	63
65	RESPIRATORY THERAPY	7,823,511		7,823,511	16,558	7,840,069	65
66	PHYSICAL THERAPY	2,699,839		2,699,839		2,699,839	66
69	ELECTROCARDIOLOGY	3,261,669		3,261,669		3,261,669	69
70	ELECTROENCEPHALOGRAPHY	204,166		204,166		204,166	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,935,810		15,935,810		15,935,810	71
72	IMPL. DEV. CHARGED TO PATIENTS	23,035,686		23,035,686		23,035,686	72
73	DRUGS CHARGED TO PATIENTS	27,182,496		27,182,496		27,182,496	73
74	RENAL DIALYSIS	1,063,550		1,063,550		1,063,550	74
76	GI LAB	1,799,200		1,799,200		1,799,200	76
76.01	MRI	2,266,477		2,266,477		2,266,477	76.01
76.02	CT SCAN	1,969,176		1,969,176		1,969,176	76.02
76.03	CARDIAC CATHETERIZATION	3,138,310		3,138,310		3,138,310	76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	801,283		801,283		801,283	76.08
76.10	GENETIC SERVICES	1,794,184		1,794,184		1,794,184	76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	1,663,373		1,663,373		1,663,373	90.01
90.02	ANTENATAL TEST CENTER	1,161,587		1,161,587		1,161,587	90.02
90.03	CHILD PSYCHIATRIC CLINIC	649,056		649,056		649,056	90.03
91	EMERGENCY	14,937,698		14,937,698	85,259	15,022,957	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,479,397		5,479,397		5,479,397	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	3,178,133		3,178,133	6,301	3,184,434	95
98	AIR AMBULANCE						98
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 (SEE INSTRUCTIONS)	281,826,476		281,826,476	2,007,355	283,833,831	200
201	LESS OBSERVATION BEDS	5,479,397		5,479,397		5,479,397	201
202	TOTAL (SEE INSTRUCTIONS)	276,347,079		276,347,079		278,354,434	202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	44,811,886		44,811,886				30
31	INTENSIVE CARE UNIT	15,374,850		15,374,850				31
34.01	NEONATAL INTENSIVE CARE	39,527,806		39,527,806				34.01
34.02	PEDIATRIC INTENSIVE CARE	3,966,429		3,966,429				34.02
40	SUBPROVIDER - IPF	4,978,735		4,978,735				40
43	NURSERY	7,495,518		7,495,518				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	33,263,354	26,948,977	60,212,331	0.408834	0.408834	0.424836	50
51	RECOVERY ROOM	3,404,475	2,588,902	5,993,377	0.374805	0.374805	0.374805	51
52	DELIVERY ROOM & LABOR ROOM	10,348,126	2,239,837	12,587,963	0.596562	0.596562	0.600641	52
53	ANESTHESIOLOGY	6,060,050	5,092,098	11,152,148	0.429742	0.429742	0.499644	53
54	RADIOLOGY-DIAGNOSTIC	17,104,732	18,346,776	35,451,508	0.216520	0.216520	0.216520	54
55	RADIOLOGY-THERAPEUTIC	333,952	11,446,090	11,780,042	0.261717	0.261717	0.261717	55
56	RADIOISOTOPE	1,517,174	6,170,245	7,687,419	0.147399	0.147399	0.147399	56
60	LABORATORY	40,754,851	21,605,268	62,360,119	0.277182	0.277182	0.277182	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	9,237,760	1,253,043	10,490,803	0.190152	0.190152	0.190152	63
65	RESPIRATORY THERAPY	27,083,098	6,886,701	33,969,799	0.230308	0.230308	0.230795	65
66	PHYSICAL THERAPY	4,598,314	1,537,858	6,136,172	0.439988	0.439988	0.439988	66
69	ELECTROCARDIOLOGY	9,201,898	15,963,524	25,165,422	0.129609	0.129609	0.129609	69
70	ELECTROENCEPHALOGRAPHY	971,124	574,578	1,545,702	0.132086	0.132086	0.132086	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,973,015	37,139,564	127,112,579	0.125368	0.125368	0.125368	71
72	IMPL. DEV. CHARGED TO PATIENTS	58,630,039	21,456,426	80,086,465	0.287635	0.287635	0.287635	72
73	DRUGS CHARGED TO PATIENTS	63,252,678	44,780,912	108,033,590	0.251612	0.251612	0.251612	73
74	RENAL DIALYSIS	1,331,358	78,857	1,410,215	0.754176	0.754176	0.754176	74
76	GI LAB	1,727,035	2,787,941	4,514,976	0.398496	0.398496	0.398496	76
76.01	MRI	6,022,746	16,773,358	22,796,104	0.099424	0.099424	0.099424	76.01
76.02	CT SCAN	15,907,261	27,483,739	43,391,000	0.045382	0.045382	0.045382	76.02
76.03	CARDIAC CATHETERIZATION	9,416,263	7,944,966	17,361,229	0.180765	0.180765	0.180765	76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES	17,036	2,195,114	2,212,150	0.362219	0.362219	0.362219	76.08
76.10	GENETIC SERVICES	83,940	807,380	891,320	2.012952	2.012952	2.012952	76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER	113,915	6,160,376	6,274,291	0.265109	0.265109	0.265109	90.01
90.02	ANTENATAL TEST CENTER	325,238	5,607,166	5,932,404	0.195804	0.195804	0.195804	90.02
90.03	CHILD PSYCHIATRIC CLINIC		310,959	310,959	2.087272	2.087272	2.087272	90.03
91	EMERGENCY	14,806,655	35,353,317	50,159,972	0.297801	0.297801	0.299501	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		13,908,596	13,908,596	0.393958	0.393958	0.393958	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	169,069	2,555,478	2,724,547	1.166481	1.166481	1.168794	95
98	AIR AMBULANCE							98
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 (SEE INSTRUCTIONS)	541,810,380	345,998,046	887,808,426				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	541,810,380	345,998,046	887,808,426				202

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	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)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	3,071,243		3,071,243	51,504	59.63	20,788	1,239,588	30
31	INTENSIVE CARE UNIT	582,120		582,120	5,496	105.92	2,310	244,675	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
34.01	NEONATAL INTENSIVE CARE	558,536		558,536	11,545	48.38			34.01
34.02	PEDIATRIC INTENSIVE CARE	69,328		69,328	1,131	61.30			34.02
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	168,640		168,640	4,084	41.29	1,304	53,842	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	92,838		92,838	2,491	37.27			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	4,542,705		4,542,705	76,251		24,402	1,538,105	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,338,841	60,212,331	0.038843	14,342,218	557,095	50
51	RECOVERY ROOM	64,801	5,993,377	0.010812	1,246,971	13,482	51
52	DELIVERY ROOM & LABOR ROOM	481,335	12,587,963	0.038238	42,613	1,629	52
53	ANESTHESIOLOGY	375,738	11,152,148	0.033692	2,080,027	70,080	53
54	RADIOLOGY-DIAGNOSTIC	853,094	35,451,508	0.024064	6,842,165	164,650	54
55	RADIOLOGY-THERAPEUTIC	430,794	11,780,042	0.036570	121,295	4,436	55
56	RADIOISOTOPE	69,077	7,687,419	0.008986	883,884	7,943	56
60	LABORATORY	1,224,036	62,360,119	0.019629	18,097,685	355,239	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	72,153	10,490,803	0.006878	3,687,169	25,360	63
65	RESPIRATORY THERAPY	491,155	33,969,799	0.014459	7,028,128	101,620	65
66	PHYSICAL THERAPY	75,139	6,136,172	0.012245	2,278,600	27,901	66
69	ELECTROCARDIOLOGY	416,905	25,165,422	0.016567	4,599,924	76,207	69
70	ELECTROENCEPHALOGRAPHY	20,361	1,545,702	0.013173	414,620	5,462	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	632,481	127,112,579	0.004976	35,065,378	174,485	71
72	IMPL. DEV. CHARGED TO PATIENTS	917,855	80,086,465	0.011461	21,924,645	251,278	72
73	DRUGS CHARGED TO PATIENTS	1,027,389	108,033,590	0.009510	26,114,839	248,352	73
74	RENAL DIALYSIS	59,496	1,410,215	0.042189	896,380	37,817	74
76	GI LAB	308,844	4,514,976	0.068404	840,910	57,522	76
76.01	MRI	552,595	22,796,104	0.024241	2,725,136	66,060	76.01
76.02	CT SCAN	151,709	43,391,000	0.003496	6,748,466	23,593	76.02
76.03	CARDIAC CATHETERIZATION	573,397	17,361,229	0.033027	4,290,047	141,687	76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	41,802	2,212,150	0.018897			76.08
76.10	GENETIC SERVICES	114,599	891,320	0.128572			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	101,407	6,274,291	0.016162	4,920	80	90.01
90.02	ANTENATAL TEST CENTER	57,946	5,932,404	0.009768			90.02
90.03	CHILD PSYCHIATRIC CLINIC	21,393	310,959	0.068797			90.03
91	EMERGENCY	1,067,584	50,159,972	0.021284	6,811,257	144,971	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	304,298	13,908,596	0.021878			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
98	AIR AMBULANCE						98
200	TOTAL (sum of lines 50-199)	12,846,224	768,928,655		167,087,277	2,556,949	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS; [XX] TITLE XVIII, PART A [ ] TEFRA; [ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		151,670			151,670	30
31	INTENSIVE CARE UNIT		78,931			78,931	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
34.01	NEONATAL INTENSIVE CARE		30,246			30,246	34.01
34.02	PEDIATRIC INTENSIVE CARE		3,144			3,144	34.02
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF		7,591			7,591	40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY		7,170			7,170	43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		278,752			278,752	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] PPS**
[XX] TITLE XVIII, PART A [ ] TEFRA
[ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	51,504	2.94	20,788	61,117	30
31	INTENSIVE CARE UNIT	5,496	14.36	2,310	33,172	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
34.01	NEONATAL INTENSIVE CARE	11,545	2.62			34.01
34.02	PEDIATRIC INTENSIVE CARE	1,131	2.78			34.02
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	4,084	1.86	1,304	2,425	40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,491	2.88			43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	76,251		24,402	96,714	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			171,068		171,068	171,068	50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM			32,676		32,676	32,676	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			322,585		322,585	322,585	54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			24,987		24,987	24,987	65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	EMERGENCY			903,392		903,392	903,392	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			15,030		15,030	15,030	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
98	AIR AMBULANCE							98
200	TOTAL (sum of lines 50-199)			1,469,738		1,469,738	1,469,738	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	60,212,331	0.002841	0.002841	14,342,218	40,746	10,688,747	30,367	50
51	RECOVERY ROOM	5,993,377			1,246,971		701,449		51
52	DELIVERY ROOM & LABOR ROOM	12,587,963	0.002596	0.002596	42,613	111	8,252	21	52
53	ANESTHESIOLOGY	11,152,148			2,080,027		1,449,530		53
54	RADIOLOGY-DIAGNOSTIC	35,451,508	0.009099	0.009099	6,842,165	62,257	5,687,847	51,754	54
55	RADIOLOGY-THERAPEUTIC	11,780,042			121,295		2,979,937		55
56	RADIOISOTOPE	7,687,419			883,884		2,694,305		56
60	LABORATORY	62,360,119			18,097,685		786,968		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	10,490,803			3,687,169		380,616		63
65	RESPIRATORY THERAPY	33,969,799	0.000736	0.000736	7,028,128	5,173	388,579	286	65
66	PHYSICAL THERAPY	6,136,172			2,278,600		428		66
69	ELECTROCARDIOLOGY	25,165,422			4,599,924		4,698,541		69
70	ELECTROENCEPHALOGRAPHY	1,545,702			414,620		1,780,662		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,112,579			35,065,378		12,555,814		71
72	IMPL. DEV. CHARGED TO PATIENTS	80,086,465			21,924,645		8,272,247		72
73	DRUGS CHARGED TO PATIENTS	108,033,590			26,114,839		17,275,877		73
74	RENAL DIALYSIS	1,410,215			896,380		48,561		74
76	GI LAB	4,514,976			840,910		687,317		76
76.01	MRI	22,796,104			2,725,136		4,360,604		76.01
76.02	CT SCAN	43,391,000			6,748,466		7,669,260		76.02
76.03	CARDIAC CATHETERIZATION	17,361,229			4,290,047		3,717,325		76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,212,150							76.08
76.10	GENETIC SERVICES	891,320							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	6,274,291			4,920		328,455		90.01
90.02	ANTENATAL TEST CENTER	5,932,404							90.02
90.03	CHILD PSYCHIATRIC CLINIC	310,959							90.03
91	EMERGENCY	50,159,972	0.018010	0.018010	6,811,257	122,671	9,993,150	179,977	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,908,596	0.001081	0.001081			2,591,231	2,801	92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
98	AIR AMBULANCE								98
200	TOTAL (sum of lines 50-199)	768,928,655			167,087,277	230,958	99,745,702	265,206	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.408834	10,688,747			4,369,923			50
51	RECOVERY ROOM	0.374805	701,449			262,907			51
52	DELIVERY ROOM & LABOR ROOM	0.596562	8,252			4,923			52
53	ANESTHESIOLOGY	0.429742	1,449,530			622,924			53
54	RADIOLOGY-DIAGNOSTIC	0.216520	5,687,847			1,231,533			54
55	RADIOLOGY-THERAPEUTIC	0.261717	2,979,937			779,900			55
56	RADIOISOTOPE	0.147399	2,694,305			397,138			56
60	LABORATORY	0.277182	786,968	33,011		218,133	9,150		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152	380,616			72,375			63
65	RESPIRATORY THERAPY	0.230308	388,579			89,493			65
66	PHYSICAL THERAPY	0.439988	428			188			66
69	ELECTROCARDIOLOGY	0.129609	4,698,541			608,973			69
70	ELECTROENCEPHALOGRAPHY	0.132086	1,780,662			235,201			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368	12,555,814			1,574,097			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635	8,272,247			2,379,388			72
73	DRUGS CHARGED TO PATIENTS	0.251612	17,275,877		155,101	4,346,818		39,025	73
74	RENAL DIALYSIS	0.754176	48,561			36,624			74
76	GI LAB	0.398496	687,317			273,893			76
76.01	MRI	0.099424	4,360,604			433,549			76.01
76.02	CT SCAN	0.045382	7,669,260			348,046			76.02
76.03	CARDIAC CATHETERIZATION	0.180765	3,717,325			671,962			76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219							76.08
76.10	GENETIC SERVICES	2.012952							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.265109	328,455			87,076			90.01
90.02	ANTENATAL TEST CENTER	0.195804							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272							90.03
91	EMERGENCY	0.297801	9,993,150			2,975,970			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958	2,591,231			1,020,836			92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	1.166481							95
98	AIR AMBULANCE								98
200	SUBTOTAL (see instructions)		99,745,702	33,011	155,101	23,041,870	9,150	39,025	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		99,745,702	33,011	155,101	23,041,870	9,150	39,025	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,338,841	60,212,331	0.038843			50
51	RECOVERY ROOM	64,801	5,993,377	0.010812			51
52	DELIVERY ROOM & LABOR ROOM	481,335	12,587,963	0.038238			52
53	ANESTHESIOLOGY	375,738	11,152,148	0.033692			53
54	RADIOLOGY-DIAGNOSTIC	853,094	35,451,508	0.024064	8,416	203	54
55	RADIOLOGY-THERAPEUTIC	430,794	11,780,042	0.036570			55
56	RADIOISOTOPE	69,077	7,687,419	0.008986			56
60	LABORATORY	1,224,036	62,360,119	0.019629	231,977	4,553	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	72,153	10,490,803	0.006878			63
65	RESPIRATORY THERAPY	491,155	33,969,799	0.014459	28,187	408	65
66	PHYSICAL THERAPY	75,139	6,136,172	0.012245	5,854	72	66
69	ELECTROCARDIOLOGY	416,905	25,165,422	0.016567	7,517	125	69
70	ELECTROENCEPHALOGRAPHY	20,361	1,545,702	0.013173	1,121	15	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	632,481	127,112,579	0.004976	1,479	7	71
72	IMPL. DEV. CHARGED TO PATIENTS	917,855	80,086,465	0.011461			72
73	DRUGS CHARGED TO PATIENTS	1,027,389	108,033,590	0.009510	232,303	2,209	73
74	RENAL DIALYSIS	59,496	1,410,215	0.042189			74
76	GI LAB	308,844	4,514,976	0.068404			76
76.01	MRI	552,595	22,796,104	0.024241			76.01
76.02	CT SCAN	151,709	43,391,000	0.003496	13,566	47	76.02
76.03	CARDIAC CATHETERIZATION	573,397	17,361,229	0.033027			76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	41,802	2,212,150	0.018897			76.08
76.10	GENETIC SERVICES	114,599	891,320	0.128572			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	101,407	6,274,291	0.016162			90.01
90.02	ANTENATAL TEST CENTER	57,946	5,932,404	0.009768			90.02
90.03	CHILD PSYCHIATRIC CLINIC	21,393	310,959	0.068797			90.03
91	EMERGENCY	1,067,584	50,159,972	0.021284	163,606	3,482	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		13,908,596				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
98	AIR AMBULANCE						98
200	TOTAL (sum of lines 50-199)	12,541,926	768,928,655		694,026	11,121	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**	
	[XX] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**			

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			171,068		171,068	171,068	50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM			32,676		32,676	32,676	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			322,585		322,585	322,585	54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			24,987		24,987	24,987	65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	EMERGENCY			903,392		903,392	903,392	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
98	AIR AMBULANCE							98
200	TOTAL (sum of lines 50-199)			1,454,708		1,454,708	1,454,708	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

(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	60,212,331	0.002841	0.002841					50
51	RECOVERY ROOM	5,993,377							51
52	DELIVERY ROOM & LABOR ROOM	12,587,963	0.002596	0.002596					52
53	ANESTHESIOLOGY	11,152,148							53
54	RADIOLOGY-DIAGNOSTIC	35,451,508	0.009099	0.009099	8,416	77			54
55	RADIOLOGY-THERAPEUTIC	11,780,042							55
56	RADIOISOTOPE	7,687,419							56
60	LABORATORY	62,360,119			231,977				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	10,490,803							63
65	RESPIRATORY THERAPY	33,969,799	0.000736	0.000736	28,187	21			65
66	PHYSICAL THERAPY	6,136,172			5,854				66
69	ELECTROCARDIOLOGY	25,165,422			7,517				69
70	ELECTROENCEPHALOGRAPHY	1,545,702			1,121				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,112,579			1,479				71
72	IMPL. DEV. CHARGED TO PATIENTS	80,086,465							72
73	DRUGS CHARGED TO PATIENTS	108,033,590			232,303				73
74	RENAL DIALYSIS	1,410,215							74
76	GI LAB	4,514,976							76
76.01	MRI	22,796,104							76.01
76.02	CT SCAN	43,391,000			13,566				76.02
76.03	CARDIAC CATHETERIZATION	17,361,229							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,212,150							76.08
76.10	GENETIC SERVICES	891,320							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	6,274,291							90.01
90.02	ANTENATAL TEST CENTER	5,932,404							90.02
90.03	CHILD PSYCHIATRIC CLINIC	310,959							90.03
91	EMERGENCY	50,159,972	0.018010	0.018010	163,606	2,947			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,908,596							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
98	AIR AMBULANCE								98
200	TOTAL (sum of lines 50-199)	768,928,655			694,026	3,045			200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.408834							50
51	RECOVERY ROOM	0.374805							51
52	DELIVERY ROOM & LABOR ROOM	0.596562							52
53	ANESTHESIOLOGY	0.429742							53
54	RADIOLOGY-DIAGNOSTIC	0.216520							54
55	RADIOLOGY-THERAPEUTIC	0.261717							55
56	RADIOISOTOPE	0.147399							56
60	LABORATORY	0.277182							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152							63
65	RESPIRATORY THERAPY	0.230308							65
66	PHYSICAL THERAPY	0.439988							66
69	ELECTROCARDIOLOGY	0.129609							69
70	ELECTROENCEPHALOGRAPHY	0.132086							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635							72
73	DRUGS CHARGED TO PATIENTS	0.251612							73
74	RENAL DIALYSIS	0.754176							74
76	GI LAB	0.398496							76
76.01	MRI	0.099424							76.01
76.02	CT SCAN	0.045382							76.02
76.03	CARDIAC CATHETERIZATION	0.180765							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219							76.08
76.10	GENETIC SERVICES	2.012952							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.265109							90.01
90.02	ANTENATAL TEST CENTER	0.195804							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272							90.03
91	EMERGENCY	0.297801							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	1.166481							95
98	AIR AMBULANCE								98
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

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	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)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	3,071,243		3,071,243	51,504	59.63	7,755	462,431	30
31	INTENSIVE CARE UNIT	582,120		582,120	5,496	105.92	826	87,490	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
34.01	NEONATAL INTENSIVE CARE	558,536		558,536	11,545	48.38	6,606	319,598	34.01
34.02	PEDIATRIC INTENSIVE CARE	69,328		69,328	1,131	61.30	842	51,615	34.02
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	168,640		168,640	4,084	41.29	745	30,761	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	92,838		92,838	2,491	37.27	1,303	48,563	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	4,542,705		4,542,705	76,251		18,077	1,000,458	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER)
[ ] TITLE XVIII, PART A [ ] IPF
[XX] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,338,841	60,212,331	0.038843			50
51	RECOVERY ROOM	64,801	5,993,377	0.010812			51
52	DELIVERY ROOM & LABOR ROOM	481,335	12,587,963	0.038238			52
53	ANESTHESIOLOGY	375,738	11,152,148	0.033692			53
54	RADIOLOGY-DIAGNOSTIC	853,094	35,451,508	0.024064			54
55	RADIOLOGY-THERAPEUTIC	430,794	11,780,042	0.036570			55
56	RADIOISOTOPE	69,077	7,687,419	0.008986			56
60	LABORATORY	1,224,036	62,360,119	0.019629			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	72,153	10,490,803	0.006878			63
65	RESPIRATORY THERAPY	491,155	33,969,799	0.014459			65
66	PHYSICAL THERAPY	75,139	6,136,172	0.012245			66
69	ELECTROCARDIOLOGY	416,905	25,165,422	0.016567			69
70	ELECTROENCEPHALOGRAPHY	20,361	1,545,702	0.013173			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	632,481	127,112,579	0.004976			71
72	IMPL. DEV. CHARGED TO PATIENTS	917,855	80,086,465	0.011461			72
73	DRUGS CHARGED TO PATIENTS	1,027,389	108,033,590	0.009510			73
74	RENAL DIALYSIS	59,496	1,410,215	0.042189			74
76	GI LAB	308,844	4,514,976	0.068404			76
76.01	MRI	552,595	22,796,104	0.024241			76.01
76.02	CT SCAN	151,709	43,391,000	0.003496			76.02
76.03	CARDIAC CATHETERIZATION	573,397	17,361,229	0.033027			76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	41,802	2,212,150	0.018897			76.08
76.10	GENETIC SERVICES	114,599	891,320	0.128572			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	101,407	6,274,291	0.016162			90.01
90.02	ANTENATAL TEST CENTER	57,946	5,932,404	0.009768			90.02
90.03	CHILD PSYCHIATRIC CLINIC	21,393	310,959	0.068797			90.03
91	EMERGENCY	1,067,584	50,159,972	0.021284			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	304,298	13,908,596	0.021878			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
98	AIR AMBULANCE						98
200	TOTAL (sum of lines 50-199)	12,846,224	768,928,655				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)		151,670			151,670	30
31	INTENSIVE CARE UNIT		78,931			78,931	31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
34.01	NEONATAL INTENSIVE CARE		30,246			30,246	34.01
34.02	PEDIATRIC INTENSIVE CARE		3,144			3,144	34.02
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF		7,591			7,591	40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY		7,170			7,170	43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)		278,752			278,752	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX**

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	51,504	2.94	7,755	22,800	30
31	INTENSIVE CARE UNIT	5,496	14.36	826	11,861	31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
34.01	NEONATAL INTENSIVE CARE	11,545	2.62	6,606	17,308	34.01
34.02	PEDIATRIC INTENSIVE CARE	1,131	2.78	842	2,341	34.02
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	4,084	1.86	745	1,386	40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,491	2.88	1,303	3,753	43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	76,251		18,077	59,449	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			171,068		171,068	171,068	50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM			32,676		32,676	32,676	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			322,585		322,585	322,585	54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			24,987		24,987	24,987	65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	EMERGENCY			903,392		903,392	903,392	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
98	AIR AMBULANCE							98
200	TOTAL (sum of lines 50-199)			1,454,708		1,454,708	1,454,708	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	60,212,331	0.002841	0.002841					50
51	RECOVERY ROOM	5,993,377							51
52	DELIVERY ROOM & LABOR ROOM	12,587,963	0.002596	0.002596					52
53	ANESTHESIOLOGY	11,152,148							53
54	RADIOLOGY-DIAGNOSTIC	35,451,508	0.009099	0.009099					54
55	RADIOLOGY-THERAPEUTIC	11,780,042							55
56	RADIOISOTOPE	7,687,419							56
60	LABORATORY	62,360,119							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	10,490,803							63
65	RESPIRATORY THERAPY	33,969,799	0.000736	0.000736					65
66	PHYSICAL THERAPY	6,136,172							66
69	ELECTROCARDIOLOGY	25,165,422							69
70	ELECTROENCEPHALOGRAPHY	1,545,702							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,112,579							71
72	IMPL. DEV. CHARGED TO PATIENTS	80,086,465							72
73	DRUGS CHARGED TO PATIENTS	108,033,590							73
74	RENAL DIALYSIS	1,410,215							74
76	GI LAB	4,514,976							76
76.01	MRI	22,796,104							76.01
76.02	CT SCAN	43,391,000							76.02
76.03	CARDIAC CATHETERIZATION	17,361,229							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,212,150							76.08
76.10	GENETIC SERVICES	891,320							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	6,274,291							90.01
90.02	ANTENATAL TEST CENTER	5,932,404							90.02
90.03	CHILD PSYCHIATRIC CLINIC	310,959							90.03
91	EMERGENCY	50,159,972	0.018010	0.018010					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,908,596							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
98	AIR AMBULANCE								98
200	TOTAL (sum of lines 50-199)	768,928,655							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0239** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.408834							50
51	RECOVERY ROOM	0.374805							51
52	DELIVERY ROOM & LABOR ROOM	0.596562							52
53	ANESTHESIOLOGY	0.429742							53
54	RADIOLOGY-DIAGNOSTIC	0.216520							54
55	RADIOLOGY-THERAPEUTIC	0.261717							55
56	RADIOISOTOPE	0.147399							56
60	LABORATORY	0.277182							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152							63
65	RESPIRATORY THERAPY	0.230308							65
66	PHYSICAL THERAPY	0.439988							66
69	ELECTROCARDIOLOGY	0.129609							69
70	ELECTROENCEPHALOGRAPHY	0.132086							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635							72
73	DRUGS CHARGED TO PATIENTS	0.251612							73
74	RENAL DIALYSIS	0.754176							74
76	GI LAB	0.398496							76
76.01	MRI	0.099424							76.01
76.02	CT SCAN	0.045382							76.02
76.03	CARDIAC CATHETERIZATION	0.180765							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219							76.08
76.10	GENETIC SERVICES	2.012952							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.265109							90.01
90.02	ANTENATAL TEST CENTER	0.195804							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272							90.03
91	EMERGENCY	0.297801							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	1.166481							95
98	AIR AMBULANCE								98
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

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER)

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,338,841	60,212,331	0.038843			50
51	RECOVERY ROOM	64,801	5,993,377	0.010812			51
52	DELIVERY ROOM & LABOR ROOM	481,335	12,587,963	0.038238			52
53	ANESTHESIOLOGY	375,738	11,152,148	0.033692			53
54	RADIOLOGY-DIAGNOSTIC	853,094	35,451,508	0.024064			54
55	RADIOLOGY-THERAPEUTIC	430,794	11,780,042	0.036570			55
56	RADIOISOTOPE	69,077	7,687,419	0.008986			56
60	LABORATORY	1,224,036	62,360,119	0.019629			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	72,153	10,490,803	0.006878			63
65	RESPIRATORY THERAPY	491,155	33,969,799	0.014459			65
66	PHYSICAL THERAPY	75,139	6,136,172	0.012245			66
69	ELECTROCARDIOLOGY	416,905	25,165,422	0.016567			69
70	ELECTROENCEPHALOGRAPHY	20,361	1,545,702	0.013173			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	632,481	127,112,579	0.004976			71
72	IMPL. DEV. CHARGED TO PATIENTS	917,855	80,086,465	0.011461			72
73	DRUGS CHARGED TO PATIENTS	1,027,389	108,033,590	0.009510			73
74	RENAL DIALYSIS	59,496	1,410,215	0.042189			74
76	GI LAB	308,844	4,514,976	0.068404			76
76.01	MRI	552,595	22,796,104	0.024241			76.01
76.02	CT SCAN	151,709	43,391,000	0.003496			76.02
76.03	CARDIAC CATHETERIZATION	573,397	17,361,229	0.033027			76.03
76.04	PRIMARY PREVENTION PROGRAM						76.04
76.05	WOMEN'S HEALTH ADVANTAGE						76.05
76.07	OUTPATIENT DETOX						76.07
76.08	SPECIAL SURGICAL SERVICES	41,802	2,212,150	0.018897			76.08
76.10	GENETIC SERVICES	114,599	891,320	0.128572			76.10
76.11	CARDIOLOGY						76.11
76.12	OUTPATIENT PSYCH SERVICES						76.12
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PAIN CENTER	101,407	6,274,291	0.016162			90.01
90.02	ANTENATAL TEST CENTER	57,946	5,932,404	0.009768			90.02
90.03	CHILD PSYCHIATRIC CLINIC	21,393	310,959	0.068797			90.03
91	EMERGENCY	1,067,584	50,159,972	0.021284			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		13,908,596				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
98	AIR AMBULANCE						98
200	TOTAL (sum of lines 50-199)	12,541,926	768,928,655				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			171,068		171,068	171,068	50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM			32,676		32,676	32,676	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC			322,585		322,585	322,585	54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY			24,987		24,987	24,987	65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	EMERGENCY			903,392		903,392	903,392	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
98	AIR AMBULANCE							98
200	TOTAL (sum of lines 50-199)			1,454,708		1,454,708	1,454,708	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [XX] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		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)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	60,212,331	0.002841	0.002841					50
51	RECOVERY ROOM	5,993,377							51
52	DELIVERY ROOM & LABOR ROOM	12,587,963	0.002596	0.002596					52
53	ANESTHESIOLOGY	11,152,148							53
54	RADIOLOGY-DIAGNOSTIC	35,451,508	0.009099	0.009099					54
55	RADIOLOGY-THERAPEUTIC	11,780,042							55
56	RADIOISOTOPE	7,687,419							56
60	LABORATORY	62,360,119							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	10,490,803							63
65	RESPIRATORY THERAPY	33,969,799	0.000736	0.000736					65
66	PHYSICAL THERAPY	6,136,172							66
69	ELECTROCARDIOLOGY	25,165,422							69
70	ELECTROENCEPHALOGRAPHY	1,545,702							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,112,579							71
72	IMPL. DEV. CHARGED TO PATIENTS	80,086,465							72
73	DRUGS CHARGED TO PATIENTS	108,033,590							73
74	RENAL DIALYSIS	1,410,215							74
76	GI LAB	4,514,976							76
76.01	MRI	22,796,104							76.01
76.02	CT SCAN	43,391,000							76.02
76.03	CARDIAC CATHETERIZATION	17,361,229							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	2,212,150							76.08
76.10	GENETIC SERVICES	891,320							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	6,274,291							90.01
90.02	ANTENATAL TEST CENTER	5,932,404							90.02
90.03	CHILD PSYCHIATRIC CLINIC	310,959							90.03
91	EMERGENCY	50,159,972	0.018010	0.018010					91
92	OBSERVATION BEDS (NON-DISTINCT PART)	13,908,596							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES								95
98	AIR AMBULANCE								98
200	TOTAL (sum of lines 50-199)	768,928,655							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S239** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[ ] TITLE XVIII, PART B [XX] IPF [ ] SNF [ ] SWING BED NF
[XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			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.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.408834							50
51	RECOVERY ROOM	0.374805							51
52	DELIVERY ROOM & LABOR ROOM	0.596562							52
53	ANESTHESIOLOGY	0.429742							53
54	RADIOLOGY-DIAGNOSTIC	0.216520							54
55	RADIOLOGY-THERAPEUTIC	0.261717							55
56	RADIOISOTOPE	0.147399							56
60	LABORATORY	0.277182							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152							63
65	RESPIRATORY THERAPY	0.230308							65
66	PHYSICAL THERAPY	0.439988							66
69	ELECTROCARDIOLOGY	0.129609							69
70	ELECTROENCEPHALOGRAPHY	0.132086							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635							72
73	DRUGS CHARGED TO PATIENTS	0.251612							73
74	RENAL DIALYSIS	0.754176							74
76	GI LAB	0.398496							76
76.01	MRI	0.099424							76.01
76.02	CT SCAN	0.045382							76.02
76.03	CARDIAC CATHETERIZATION	0.180765							76.03
76.04	PRIMARY PREVENTION PROGRAM								76.04
76.05	WOMEN'S HEALTH ADVANTAGE								76.05
76.07	OUTPATIENT DETOX								76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219							76.08
76.10	GENETIC SERVICES	2.012952							76.10
76.11	CARDIOLOGY								76.11
76.12	OUTPATIENT PSYCH SERVICES								76.12
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PAIN CENTER	0.265109							90.01
90.02	ANTENATAL TEST CENTER	0.195804							90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272							90.03
91	EMERGENCY	0.297801							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	1.166481							95
98	AIR AMBULANCE								98
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

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	51,504	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	51,504	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	41,757	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,644	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	20,788	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	613.53	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	215.15	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	55,302,712	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	55,302,712	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	44,811,886	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	44,811,886	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.234108	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)	9,649.42	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 - line 36)	55,302,712	37

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,073.76	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					22,321,323	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)					22,321,323	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	13,155,366	5,496	2,393.63	2,310	5,529,285	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
46.01	NEONATAL INTENSIVE CARE	12,875,563	11,545	1,115.25			46.01
46.02	PEDIATRIC INTENSIVE CARE	2,316,812	1,131	2,048.46			46.02
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					39,940,152	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					67,790,760	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,578,552	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					2,787,907	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					4,366,459	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					63,424,301	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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
[ ] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					5,103	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,073.76	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					5,479,397	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	3,071,243	55,302,712	0.055535	5,479,397	304,298	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST	151,670	55,302,712	0.002743	5,479,397	15,030	92
93	ALL OTHER MEDICAL EDUCATION						93

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S239** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,084	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,084	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,084	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,304	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	3,816,169	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	3,816,169	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 - line 36)	3,816,169	37

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S239** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	934.42	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	1,218,484	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	1,218,484	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	184,576	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	1,403,060	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	56,267	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	14,166	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	70,433	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	1,332,627	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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	51,504	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	51,504	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	41,757	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,644	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	7,755	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 Title XIX only)	2,491	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	1,303	16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	613.53	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	215.15	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	55,235,834	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	55,235,834	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	44,811,886	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	44,811,886	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	1.232616	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)	9,649.42	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 - line 36)	55,235,834	37

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,072.46	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					8,316,927	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)					8,316,927	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	4,082,757	2,491	1,639.00	1,303	2,135,617	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	13,155,366	5,496	2,393.63	826	1,977,138	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
46.01	NEONATAL INTENSIVE CARE	12,848,563	11,545	1,112.91	6,606	7,351,883	46.01
46.02	PEDIATRIC INTENSIVE CARE	2,305,876	1,131	2,038.79	842	1,716,661	46.02
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					21,498,226	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,027,760	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					1,027,760	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

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0239** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] NF [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)	5,103	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)		88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)		89

		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S239** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,084	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,084	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,084	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	745	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	3,816,169	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	3,816,169	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 - line 36)	3,816,169	37

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S239** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [ ] TITLE XVIII, PART A [XX] TITLE XIX - I/P | [ ] HOSPITAL [XX] IPF [ ] IRF | [ ] SUB (OTHER) | [ ] PPS [ ] TEFRA [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	934.42	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	696,143	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)	696,143	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	696,143	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	32,147	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	32,147	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

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0239** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		21,708,595		30
31	INTENSIVE CARE UNIT		7,025,231		31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.424836	14,342,218	6,093,091	50
51	RECOVERY ROOM	0.374805	1,246,971	467,371	51
52	DELIVERY ROOM & LABOR ROOM	0.600641	42,613	25,595	52
53	ANESTHESIOLOGY	0.499644	2,080,027	1,039,273	53
54	RADIOLOGY-DIAGNOSTIC	0.216520	6,842,165	1,481,466	54
55	RADIOLOGY-THERAPEUTIC	0.261717	121,295	31,745	55
56	RADIOISOTOPE	0.147399	883,884	130,284	56
60	LABORATORY	0.277182	18,097,685	5,016,353	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152	3,687,169	701,123	63
65	RESPIRATORY THERAPY	0.230795	7,028,128	1,622,057	65
66	PHYSICAL THERAPY	0.439988	2,278,600	1,002,557	66
69	ELECTROCARDIOLOGY	0.129609	4,599,924	596,192	69
70	ELECTROENCEPHALOGRAPHY	0.132086	414,620	54,765	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368	35,065,378	4,396,076	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635	21,924,645	6,306,295	72
73	DRUGS CHARGED TO PATIENTS	0.251612	26,114,839	6,570,807	73
74	RENAL DIALYSIS	0.754176	896,380	676,028	74
76	GI LAB	0.398496	840,910	335,099	76
76.01	MRI	0.099424	2,725,136	270,944	76.01
76.02	CT SCAN	0.045382	6,748,466	306,259	76.02
76.03	CARDIAC CATHETERIZATION	0.180765	4,290,047	775,490	76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219			76.08
76.10	GENETIC SERVICES	2.012952			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.265109	4,920	1,304	90.01
90.02	ANTENATAL TEST CENTER	0.195804			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272			90.03
91	EMERGENCY	0.299501	6,811,257	2,039,978	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
98	AIR AMBULANCE				98
200	TOTAL (sum of lines 50-94, and 96-98)		167,087,277	39,940,152	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		167,087,277		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S239** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	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		1,587,365		40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.424836			50
51	RECOVERY ROOM	0.374805			51
52	DELIVERY ROOM & LABOR ROOM	0.600641			52
53	ANESTHESIOLOGY	0.499644			53
54	RADIOLOGY-DIAGNOSTIC	0.216520	8,416	1,822	54
55	RADIOLOGY-THERAPEUTIC	0.261717			55
56	RADIOISOTOPE	0.147399			56
60	LABORATORY	0.277182	231,977	64,300	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152			63
65	RESPIRATORY THERAPY	0.230795	28,187	6,505	65
66	PHYSICAL THERAPY	0.439988	5,854	2,576	66
69	ELECTROCARDIOLOGY	0.129609	7,517	974	69
70	ELECTROENCEPHALOGRAPHY	0.132086	1,121	148	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368	1,479	185	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635			72
73	DRUGS CHARGED TO PATIENTS	0.251612	232,303	58,450	73
74	RENAL DIALYSIS	0.754176			74
76	GI LAB	0.398496			76
76.01	MRI	0.099424			76.01
76.02	CT SCAN	0.045382	13,566	616	76.02
76.03	CARDIAC CATHETERIZATION	0.180765			76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219			76.08
76.10	GENETIC SERVICES	2.012952			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.265109			90.01
90.02	ANTENATAL TEST CENTER	0.195804			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272			90.03
91	EMERGENCY	0.299501	163,606	49,000	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
98	AIR AMBULANCE				98
200	TOTAL (sum of lines 50-94, and 96-98)		694,026	184,576	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		694,026		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0239** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.408834			50
51	RECOVERY ROOM	0.374805			51
52	DELIVERY ROOM & LABOR ROOM	0.596562			52
53	ANESTHESIOLOGY	0.429742			53
54	RADIOLOGY-DIAGNOSTIC	0.216520			54
55	RADIOLOGY-THERAPEUTIC	0.261717			55
56	RADIOISOTOPE	0.147399			56
60	LABORATORY	0.277182			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152			63
65	RESPIRATORY THERAPY	0.230308			65
66	PHYSICAL THERAPY	0.439988			66
69	ELECTROCARDIOLOGY	0.129609			69
70	ELECTROENCEPHALOGRAPHY	0.132086			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635			72
73	DRUGS CHARGED TO PATIENTS	0.251612			73
74	RENAL DIALYSIS	0.754176			74
76	GI LAB	0.398496			76
76.01	MRI	0.099424			76.01
76.02	CT SCAN	0.045382			76.02
76.03	CARDIAC CATHETERIZATION	0.180765			76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219			76.08
76.10	GENETIC SERVICES	2.012952			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.265109			90.01
90.02	ANTENATAL TEST CENTER	0.195804			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272			90.03
91	EMERGENCY	0.297801			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
98	AIR AMBULANCE				98
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S239** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[XX] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
34.01	NEONATAL INTENSIVE CARE				34.01
34.02	PEDIATRIC INTENSIVE CARE				34.02
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.408834			50
51	RECOVERY ROOM	0.374805			51
52	DELIVERY ROOM & LABOR ROOM	0.596562			52
53	ANESTHESIOLOGY	0.429742			53
54	RADIOLOGY-DIAGNOSTIC	0.216520			54
55	RADIOLOGY-THERAPEUTIC	0.261717			55
56	RADIOISOTOPE	0.147399			56
60	LABORATORY	0.277182			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.190152			63
65	RESPIRATORY THERAPY	0.230308			65
66	PHYSICAL THERAPY	0.439988			66
69	ELECTROCARDIOLOGY	0.129609			69
70	ELECTROENCEPHALOGRAPHY	0.132086			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.125368			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.287635			72
73	DRUGS CHARGED TO PATIENTS	0.251612			73
74	RENAL DIALYSIS	0.754176			74
76	GI LAB	0.398496			76
76.01	MRI	0.099424			76.01
76.02	CT SCAN	0.045382			76.02
76.03	CARDIAC CATHETERIZATION	0.180765			76.03
76.04	PRIMARY PREVENTION PROGRAM				76.04
76.05	WOMEN'S HEALTH ADVANTAGE				76.05
76.07	OUTPATIENT DETOX				76.07
76.08	SPECIAL SURGICAL SERVICES	0.362219			76.08
76.10	GENETIC SERVICES	2.012952			76.10
76.11	CARDIOLOGY				76.11
76.12	OUTPATIENT PSYCH SERVICES				76.12
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PAIN CENTER	0.265109			90.01
90.02	ANTENATAL TEST CENTER	0.195804			90.02
90.03	CHILD PSYCHIATRIC CLINIC	2.087272			90.03
91	EMERGENCY	0.297801			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.393958			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
98	AIR AMBULANCE				98
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

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, 2013 (see instructions)	28,616,649			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	8,850,708			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	3,912,977			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	8,370,279			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	273.69			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0446			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.3299			31
32	SUM OF LINES 30 AND 31	0.3745			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1980			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	6,104,207			34
		PRIOR TO	ON OR AFTER		

KPMG LLP COMPU-MAX

ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		5,936,185		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,496,245		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,496,245			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I 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
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 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)				46
47	SUBTOTAL (see instructions)	48,980,786			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 SCH AND MDH ONLY (see instructions)	48,980,786			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	3,330,915			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	119,083			53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS	94,289			57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	230,958			58
59	TOTAL (sum of amounts on lines 49 through 58)	52,756,031			59
60	PRIMARY PAYER PAYMENTS	57,460			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	52,698,571			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	3,640,080			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	174,698			63
64	ALLOWABLE BAD DEBTS (see instructions)	606,040			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	393,926			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	554,071			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	49,277,719			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (MEDI/MEDI BAD DEBT RETROACTIVE ADJ)				70
71	AMOUNT DUE PROVIDER (see instructions)	49,277,719			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	744,094			71.01
72	INTERIM PAYMENTS	48,018,824			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	514,801			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	655,679			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0239** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] 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)	48,175			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	22,776,664			2
3	PPS PAYMENTS	17,925,330			3
4	OUTLIER PAYMENT (see instructions)	91,746			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	265,206			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	48,175			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	188,112			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	188,112			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)	188,112			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	139,937			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	48,175			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	18,282,282			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	3,920,910			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	14,409,547			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	14,409,547			30
31	PRIMARY PAYER PAYMENTS	2,942			31
32	SUBTOTAL (line 30 minus line 31)	14,406,605			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)	487,477			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	316,860			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	460,495			36
37	SUBTOTAL (see instructions)	14,723,465			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (FORMULA DRIVEN OVERPAYMENT EST)				39
40	SUBTOTAL (see instructions)	14,723,465			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	222,324			40.01
41	INTERIM PAYMENTS	14,696,007			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-194,866			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse 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

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S239** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ()				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse 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

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0239** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				48,018,824		14,696,007	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		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)				48,018,824		14,696,007	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		1,258,895		27,458	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				49,277,719		14,723,465	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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S239** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [XX] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				888,080			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		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)				888,080			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01		39,691			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				927,771			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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	12,532	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	23,098	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	4,730	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	64,573	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	887,808,426	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	31,754,913	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,911,640	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	38,233	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,873,407	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,935,426	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-62,019	32

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S239** **WORKSHEET E-3 PART II**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	1,010,938	1
2	NET IPF PPS OUTLIER PAYMENT	1,191	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		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 §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	11.189041	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	1,012,129	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	1,012,129	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	1,012,129	18
19	DEDUCTIBLES	107,716	19
20	SUBTOTAL (line 18 minus line 19)	904,413	20
21	COINSURANCE	2,368	21
22	SUBTOTAL (line 20 minus line 21)	902,045	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	31,163	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	20,256	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	31,163	25
26	SUBTOTAL (sum of lines 22 and 24)	922,301	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)	5,470	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	927,771	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	14,009	31.01
32	INTERIM PAYMENTS	888,080	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	25,682	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0239** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	21,498,226		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	21,498,226		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	21,498,226		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	21,498,226		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S239** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XIX** **[ ] PPS** **[ ] TEFRA** **[XX] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	696,143		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	696,143		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	696,143		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	696,143		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	37,268,913				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	55,527,705				4
5	OTHER RECEIVABLES	3,848,005				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	7,324,270				7
8	PREPAID EXPENSES	1,665,287				8
9	OTHER CURRENT ASSETS	13,160,001				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	118,794,181				11
	FIXED ASSETS					
12	LAND	2,600,972				12
13	LAND IMPROVEMENTS	7,188,799				13
14	ACCUMULATED DEPRECIATION	-5,916,971				14
15	BUILDINGS	54,588,562				15
16	ACCUMULATED DEPRECIATION	-39,393,511				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	110,258,508				19
20	ACCUMULATED DEPRECIATION	-77,672,946				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	134,574,447				23
24	ACCUMULATED DEPRECIATION	-89,929,538				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)	96,298,322				30
	OTHER ASSETS					
31	INVESTMENTS	100,088,445				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	23,235,624				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	123,324,069				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	338,416,572				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	6,977,167				37
38	SALARIES, WAGES & FEES PAYABLE	25,326,154				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	3,211,403				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	2,644				43
44	OTHER CURRENT LIABILITIES	13,249,472				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	48,766,840				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	62,061,132				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	45,133,435				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	107,194,567				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	155,961,407				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	182,455,165				52
53	SPECIFIC PURPOSE FUND BALANCE					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

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	182,455,165				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	338,416,572				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		175,355,785			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		57,354,480			2
3	TOTAL (sun of line 1 and line 2)		232,710,265			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		232,710,265			11
12	DEDUCTIONS (debit adjustments)					12
13	OTHER	50,255,000				13
14						14
15						15
16	OTHER					16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		50,255,000			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		182,455,265			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	OTHER					13
14						14
15						15
16	OTHER					16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	45,360,209		45,360,209	1
2	SUBPROVIDER IPF	4,978,396		4,978,396	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)	50,338,605		50,338,605	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	15,070,870		15,070,870	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
14.01	NEONATAL INTENSIVE CARE	46,668,719		46,668,719	14.01
14.02	PEDIATRIC INTENSIVE CARE	3,964,617		3,964,617	14.02
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	65,704,206		65,704,206	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	116,042,811		116,042,811	17
18	ANCILLARY SERVICES	425,961,095	346,145,000	772,106,095	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	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)	542,003,906	346,145,000	888,148,906	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		296,843,599	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38	PHYSICIAN PRACTICE REVENUE	-312,079		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-312,079	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		296,531,520	43

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	888,148,906	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	605,872,906	2
3	NET PATIENT REVENUES (line 1 minus line 2)	282,276,000	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	296,531,520	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-14,255,520	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 OTHER 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, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING INCOME)	28,256,000	24
24.01	OTHER (OTHER NON-OPERATING INCOME)	18,194,000	24.01
24.02	OTHER (PROVIDER TAX)	25,160,000	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	71,610,000	25
26	TOTAL (line 5 plus line 25)	57,354,480	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	57,354,480	29

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0239** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	2,979,326	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	117,116	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)	176.91	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0446	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.3299	8
9	SUM OF LINES 7 AND 8	0.3745	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0787	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	234,473	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	3,330,915	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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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
34.01	NEONATAL INTENSIVE CARE							34.01
34.02	PEDIATRIC INTENSIVE CARE							34.02
40	SUBPROVIDER - IPF							40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	GI LAB							76
76.01	MRI							76.01
76.02	CT SCAN							76.02
76.03	CARDIAC CATHETERIZATION							76.03
76.04	PRIMARY PREVENTION PROGRAM							76.04
76.05	WOMEN'S HEALTH ADVANTAGE							76.05
76.07	OUTPATIENT DETOX							76.07
76.08	SPECIAL SURGICAL SERVICES							76.08
76.10	GENETIC SERVICES							76.10
76.11	CARDIOLOGY							76.11
76.12	OUTPATIENT PSYCH SERVICES							76.12
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PAIN CENTER							90.01
90.02	ANTENATAL TEST CENTER							90.02
90.03	CHILD PSYCHIATRIC CLINIC							90.03
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

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ROCKFORD MEMORIAL HOSPITAL Provider CCN: 14-0239	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/22/2014 Run Time: 07:53 Version: 2014.03

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		
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
98	AIR AMBULANCE							98
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							
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
194.07	ROCKFORD HEALTH SYSTEM							194.07
194.08	DIALYSIS RENTED SPACE							194.08
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202