

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

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

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 06/30/2015 Time: 13:38	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BELOIT MEMORIAL HOSPITAL, INC. (52-0100) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		226,175	79,011	38,140	-2,241	1
2	SUBPROVIDER - IPF						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			-1,417			9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		226,175	77,594	38,140	-2,241	200

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: BELOIT MEMORIAL HOSPITAL	P.O. Box: 1969 WEST								1
2	City: BELOIT	State: WI	ZIP Code: 53511	County: ROCK						2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	BELOIT MEMORIAL HOSPITAL, INC.	52-0100	27500	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									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	AT HOME HEALTHCARE	52-7075	27500		09 / 01 / 1996	N	P	N	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	BELOIT MEMORIAL DIALYSIS	52-2324	27500		01 / 01 / 2004				18
19	Other									19

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

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,210	305	224	45	1,613		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35

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PART I**

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39	
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40	
		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		I	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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65

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

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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**WORKSHEET S-2
PART I**

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

Rural Providers

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	510,098			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.	N			121

Transplant Center Information

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

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**WORKSHEET S-2
PART I**

All Providers

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

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2013	09 / 30 / 2014			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N			171

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N	Y/N
Approved Educational Activities			
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	6
7	Are costs claimed for allied health programs? If yes, see instructions.	N	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
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/15/2015	Y	04/15/2015
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: AARON	Last name: WIERSEMA	Title: SR FINANCIAL ANALYST	41
42	Employer: BELOIT HEALTH SYSTEM, INC			42
43	Phone number: 608-364-5102	E-mail Address: AWIERSEMA@BELOITHEALTHSYSTEM.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Total All Patients
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	91	33,215			8,359	912	15,855	1
2	HMO and other (see instructions)						2,114	2,187		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)		91	33,215			8,359	912	15,855	7
8	Intensive Care Unit	31	12	4,380			1,107	26	2,215	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						272	1,231	13
14	Total (see instructions)		103	37,595			9,466	1,210	19,301	14
15	CAH Visits									15
16	Subprovider - IPF	40								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					8,977	904	13,190	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)		103							27
28	Observation Bed Days							51	600	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,918	312	4,143	1
2	HMO and other (see instructions)					401	377		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
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		1,270.00			1,918	312	4,143	14
15	CAH Visits								15
16	Subprovider - IPF								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		22.00						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)		1,292.00						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	88,564,801		88,564,801	2,688,177.00	32.95	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		79,330		79,330	2,632.00	30.14	3
4	Physician-Part A - Administrative		475,251		475,251	2,481.00	191.56	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		20,647,010		20,647,010	122,539.00	168.49	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)		4,721,093		4,721,093	205,028.00	23.03	10
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)		578,702		578,702	5,906.00	97.99	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							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)		30,613,458		30,613,458			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		2,572,024		2,572,024			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		35,336		35,336			21
22	Physician Part A - Administrative		71,248		71,248			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		3,167,331		3,167,331			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department							26
27	Administrative & General		11,931,636		11,931,636	499,613.00	23.88	27
28	Administrative & General under contract (see instructions)		193,251		193,251	475.00	406.84	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,896,403		1,896,403	88,616.00	21.40	30
31	Laundry & Linen Service		46,394		46,394	4,851.00	9.56	31
32	Housekeeping		1,029,632		1,029,632	87,761.00	11.73	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		921,061		921,061	56,311.00	16.36	34
35	Dietary under contract (see instructions)							35
36	Cafeteria		100,538		100,538	9,312.00	10.80	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,165,025		1,165,025	38,060.00	30.61	38
39	Central Services and Supply		550,173		550,173	35,396.00	15.54	39
40	Pharmacy		1,662,386		1,662,386	42,026.00	39.56	40
41	Medical Records & Medical Records Library		2,119,255		2,119,255	110,159.00	19.24	41
42	Social Service		364,452		364,452	13,411.00	27.18	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		68,031,712		68,031,712	2,563,481.00	26.54	1
2	Excluded area salaries (see instructions)		4,721,093		4,721,093	205,028.00	23.03	2
3	Subtotal salaries (line 1 minus line 2)		63,310,619		63,310,619	2,358,453.00	26.84	3
4	Subtotal other wages & related costs (see instructions)		578,702		578,702	5,906.00	97.99	4
5	Subtotal wage-related costs (see instructions)		30,684,706		30,684,706		48.47%	5
6	Total (sum of lines 3 through 5)		94,574,027		94,574,027	2,364,359.00	40.00	6
7	Total overhead cost (see instructions)		21,980,206		21,980,206	985,991.00	22.29	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	3,200,199	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	1,522,967	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)	24,478,060	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	559,835	10
11	Life Insurance (If employee is owner or beneficiary)	57,481	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	215,952	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	520,937	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	5,253,035	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	89,912	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	561,019	23
24	Total Wage Related cost (Sum of lines 1-23)	36,459,397	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTS (SPECIFY)		25
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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date	09/30/2018	1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2014	12/31/2014
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	7/01/2014	3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	1/01/2013	4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	1/01/2016	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	1/01/2013	9
10	Ending Date of Averaging Period from Line 5	1/01/2016	10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
11.01		03/10/2014	220,000
11.02		04/10/2014	220,000
11.03		05/09/2014	220,000
11.04		06/09/2014	220,000
11.05		07/09/2014	220,000
11.06		08/12/2014	220,000
11.07		12/30/2014	1,500,000
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)	36	12
13	Total Contributions Made During Averaging Period	2,820,000	13
14	Average Monthly Contribution (Line 13 divided by Line 12)	78,333	14
15	Number of Months in Provider Cost Reporting Period on Line 2	12	15
16	Average Pension Contributions (Line 14 times Line 15)	939,996	16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)	582,971	17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)	582,971	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,522,967	19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 52-7075

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		3,366	341	1,236	4,943	1
2	Unduplicated Census Count (see instructions)		391.00				2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)				
		Staff 1	Contract 2	Total 3		
3	Administrator and Assistant Administrator(s)				3	
4	Director(s) and Assistant Director(s)		1.00		1.00	4
5	Other Administrative Personnel		3.00		3.00	5
6	Direct Nursing Service		11.00		11.00	6
7	Nursing Supervisor					7
8	Physical Therapy Service		3.00		3.00	8
9	Physical Therapy Supervisor					9
10	Occupational Therapy Service		1.00		1.00	10
11	Occupational Therapy Supervisor					11
12	Speech Pathology Service					12
13	Speech Pathology Supervisor					13
14	Medical Social Service					14
15	Medical Social Service Supervisor					15
16	Home Health Aide		2.00		2.00	16
17	Home Health Aide Supervisor					17
18	Other (specify)					18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	27500	20
20.01		40420	20.01
20.02		99952	20.02

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	4,377	758	277	59	5,471	21
22	Skilled Nursing Visit Charges	1,427,477	264,586	70,764	18,410	1,781,237	22
23	Physical Therapy Visits	1,698	98	67	9	1,872	23
24	Physical Therapy Visit Charges	627,990	37,167	20,176	3,492	688,825	24
25	Occupational Therapy Visits	724	55	11	2	792	25
26	Occupational Therapy Visit Charges	273,590	21,259	3,880	776	299,505	26
27	Speech Pathology Visits	9		3		12	27
28	Speech Pathology Visit Charges	3,492		776		4,268	28
29	Medical Social Service Visits	21	3			24	29
30	Medical Social Service Visit Charges	10,591	1,518			12,109	30
31	Home Health Aide Visits	1,426	150	3		1,579	31
32	Home Health Aide Visit Charges	231,286	25,145	507		256,938	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,255	1,064	361	70	9,750	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,574,426	349,675	96,103	22,678	3,042,882	35
36	Total Number of Episodes (standard/non-outlier)	470		95	7	572	36
37	Total Number of Ourlier Episodes		24			24	37
38	Total Non-Routine Medical Supply Charges	190,410	98,915	10,272	221	299,818	38

KPMG LLP Compu-Max 2552-10

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period	67					7	1
2	Number of times per week patient receives dialysis	3.00					7.00	2
3	Average patient dialysis time including setup	5.00						3
4	CAPD exchanges per day						4	4
5	Number of days in year dialysis furnished	313						5
6	Number of stations	18						6
7	Treatment capacity per day per station	6						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)	N		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)	Y		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

		9	11
11	Number of patients on transplant list		
12	Number of patients transplanted during the cost reporting period	3	12

EPOETIN

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

ARANESP

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

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

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

KPMG LLP Compu-Max 2552-10

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.251390	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	16,966,140	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?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	100,535,447	6
7	Medicaid cost (line 1 times line 6)	25,273,615	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.	8,307,475	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,307,475	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	12,727,496		12,727,496	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,199,566		3,199,566	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	3,199,566		3,199,566	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)	10,350,795	26
27	Medicare bad debts for the entire hospital complex (see instructions)	196,687	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	10,154,108	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,552,642	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	5,752,208	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,059,683	31

KPMG LLP Compu-Max 2552-10

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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- FICATION S	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		6,581,026	6,581,026	4,036,627	10,617,653	-1,181,395	9,436,258	1
2	00200	Cap Rel Costs-Mvble Equip		3,486,901	3,486,901	1,087,635	4,574,536		4,574,536	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		34,337,806	34,337,806		34,337,806	-8,900,473	25,437,333	4
5	00500	Administrative & General	11,931,636	19,190,924	31,122,560	-1,022,741	30,099,819	-6,278,109	23,821,710	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,896,403	5,284,722	7,181,125	-40,517	7,140,608	-509,902	6,630,706	7
8	00800	Laundry & Linen Service	46,394	486,205	532,599		532,599	-15,459	517,140	8
9	00900	Housekeeping	1,029,632	238,898	1,268,530		1,268,530	-219,615	1,048,915	9
10	01000	Dietary	921,061	416,064	1,337,125		1,337,125	-90	1,337,035	10
11	01100	Cafeteria	100,538	547,290	647,828		647,828	-600,090	47,738	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,165,025	13,548	1,178,573		1,178,573	-328,980	849,593	13
14	01400	Central Services & Supply	550,173	314,589	864,762	-41,063	823,699	-112	823,587	14
15	01500	Pharmacy	1,662,386	72,595	1,734,981	-31,250	1,703,731	-6,104	1,697,627	15
16	01600	Medical Records & Library	2,119,255	1,756,747	3,876,002		3,876,002	-494,188	3,381,814	16
17	01700	Social Service	364,452	5,302	369,754		369,754		369,754	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	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,800,607	250,536	7,051,143		7,051,143	-2,445	7,048,698	30
31	03100	Intensive Care Unit	1,712,687	38,980	1,751,667		1,751,667		1,751,667	31
43	04300	Nursery	171,875		171,875		171,875		171,875	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,979,054	753,490	2,732,544	-3,219	2,729,325	-34	2,729,291	50
51	05100	Recovery Room	381,854	7,927	389,781		389,781		389,781	51
52	05200	Delivery Room & Labor Room	424,633		424,633		424,633		424,633	52
53	05300	Anesthesiology	79,330	134,347	213,677		213,677	-79,330	134,347	53
54	05400	Radiology-Diagnostic	1,467,380	659,664	2,127,044		2,127,044	-297,445	1,829,599	54
55	05500	Radiology-Therapeutic	369,638	262,444	632,082		632,082		632,082	55
57	05700	CT Scan	708,397	469,951	1,178,348	-399	1,177,949		1,177,949	57
58	05800	MRI	310,622	506,518	817,140	-164,205	652,935		652,935	58
59	05900	Cardiac Catheterization	1,192,397	307,480	1,499,877		1,499,877		1,499,877	59
60	06000	Laboratory	2,844,071	3,868,207	6,712,278	-105	6,712,173	-4,665	6,707,508	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	746,927	221,950	968,877	-396	968,481		968,481	65
66	06600	Physical Therapy	2,467,854	194,944	2,662,798	-172	2,662,626	-874,404	1,788,222	66
67	06700	Occupational Therapy	243,960	44,105	288,065		288,065		288,065	67
68	06800	Speech Pathology	96,867	21,432	118,299		118,299		118,299	68
69	06900	Electrocardiology	349,603	29,672	379,275		379,275	-32,892	346,383	69
71	07100	Medical Supplies Charged to Patients		9,861,264	9,861,264		9,861,264	-612,081	9,249,183	71
73	07300	Drugs Charged to Patients		11,012,140	11,012,140		11,012,140	-1,325,669	9,686,471	73
74	07400	Renal Dialysis	986,504	504,474	1,490,978		1,490,978		1,490,978	74
75	07500	ASC (Non-Distinct Part)	408,704	9,337	418,041		418,041		418,041	75
76	03950	OTHER ANCILLARY								76
76.01	03280	SLEEP/EEG	214,017	27,281	241,298	-267	241,031		241,031	76.01
76.02	03340	GI	631,023	156,363	787,386		787,386		787,386	76.02
76.03	03450	NUCLEAR MED	270,635	544,828	815,463		815,463		815,463	76.03
76.04	03550	PSYCH	1,690,849	489,139	2,179,988	-3,457	2,176,531	-209,653	1,966,878	76.04
76.05	03630	ULTRASOUND	385,961	122,654	508,615	-18,697	489,918	-96,371	393,547	76.05
76.06	03650	VASCULAR LAB	407,449	45,706	453,155		453,155	-864	452,291	76.06
76.07	03951	MEDICAL OUTPATIENT	264,983	22,115	287,098		287,098		287,098	76.07
76.97	07697	CARDIAC REHABILITATION	193,915	5,316	199,231		199,231		199,231	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY		71,238	71,238		71,238		71,238	76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	PROVIDER BASED PHYSICIAN CLINICS	30,708,269	2,071,522	32,779,791	-75,074	32,704,717	-29,671,796	3,032,921	90.01
91	09100	Emergency	3,546,688	878,124	4,424,812		4,424,812	-394,767	4,030,045	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,492,851	172,600	1,665,451		1,665,451	-4,240	1,661,211	101

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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- FICATION S	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	
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		3,696,104	3,696,104	-3,696,104				113
118		SUBTOTALS (sum of lines 1-117)	85,336,559	110,194,469	195,531,028	26,596	195,557,624	-52,141,173	143,416,451	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	38,865	48,049	86,914		86,914		86,914	190
194	07950	PATHOLOGY	31,615	41,524	73,139		73,139		73,139	194
194.0 1	07951	PHYSIATRY CLINIC	205,166	1,832	206,998		206,998		206,998	194.0 1
194.0 2	07952	JANESVILLE MED CTR	165,430	46,923	212,353	-18,785	193,568		193,568	194.0 2
194.0 3	07953	OCCUPATIONAL HEALTH & WELLNESS	1,012,410	169,143	1,181,553	-895	1,180,658		1,180,658	194.0 3
194.0 4	07954	ASSISTED LIVING CENTERS	1,505,483	821,120	2,326,603	-6,916	2,319,687		2,319,687	194.0 4
194.0 5	07955	NORTHPOINTE FITNESS & SPA CENTER	269,273	2,128,883	2,398,156		2,398,156		2,398,156	194.0 5
200		TOTAL (sum of lines 118-199)	88,564,801	113,451,943	202,016,744		202,016,744	-52,141,173	149,875,571	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	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Bldg & Fixt	1		3,514,173	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Mvble Equip	2		181,931	2
500	Total reclassifications					3,696,104	500
	Code Letter - A						
1	RENTS AND LEASES	B	Cap Rel Costs-Bldg & Fixt	1		522,454	1
2			Cap Rel Costs-Mvble Equip	2		905,704	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
500	Total reclassifications					1,428,158	500
	Code Letter - B						
	GRAND TOTAL (Increases)					5,124,262	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS INTEREST EXPENSE TO CAPITAL	A	Interest Expense	113		3,696,104	11	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A					11	2
500	Total reclassifications					3,696,104		500
	Code letter - A							
1	RENTS AND LEASES	B	Administrative & General	5		1,022,741	10	1
2			Operation of Plant	7		40,517	10	2
3			Central Services & Supply	14		41,063	10	3
4			Pharmacy	15		31,250	10	4
5			Operating Room	50		3,219	10	5
6			CT Scan	57		399	10	6
7			MRI	58		164,205	10	7
8			Laboratory	60		105	10	8
9			Respiratory Therapy	65		396	10	9
10			Physical Therapy	66		172	10	10
11			SLEEP/EEG	76.01		267	10	11
12			PSYCH	76.04		3,457	10	12
13			ULTRASOUND	76.05		18,697	10	13
14			PROVIDER BASED PHYSICIAN CLIN	90.01		75,074	10	14
15			JANESVILLE MED CTR	194.02		18,785	10	15
16			OCCUPATIONAL HEALTH & WELLNES	194.03		895	10	16
17			ASSISTED LIVING CENTERS	194.04		6,916	10	17
500	Total reclassifications					1,428,158		500
	Code letter - B							
	GRAND TOTAL (Decreases)					5,124,262		

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

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RECONCILIATION OF CAPITAL COST CENTERS

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	8,100,877					8,100,877		1
2	Land Improvements	5,953,103	347,840		347,840		6,300,943	985,460	2
3	Buildings and Fixtures	107,891,273	9,882,894		9,882,894		117,774,167	17,199,769	3
4	Building Improvements								4
5	Fixed Equipment	32,691,129	3,674,986		3,674,986		36,366,115	8,578,001	5
6	Movable Equipment	53,837,816	3,191,920		3,191,920		57,029,736	36,034,878	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	208,474,198	17,097,640		17,097,640		225,571,838	62,798,108	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	208,474,198	17,097,640		17,097,640		225,571,838	62,798,108	10

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

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	6,581,026						6,581,026	1	
2	Cap Rel Costs-Mvble Equip	3,486,901						3,486,901	2	
3	Total (sum of lines 1-2)	10,067,927						10,067,927	3	

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

have been included in Worksheet A, column 2, lines 1 and 2.

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	160,441,225		160,441,225	0.737759					1
2	Cap Rel Costs-Mvble Equ	57,029,736		57,029,736	0.262241					2
3	Total (sum of lines 1-2)	217,470,961		217,470,961	1.000000					3

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	5,399,631	522,454	3,514,173				9,436,258	1	
2	Cap Rel Costs-Mvble Equip	3,486,901	905,704	181,931				4,574,536	2	
3	Total (sum of lines 1-2)	8,886,532	1,428,158	3,696,104				14,010,794	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trace, quantity, and time discounts (chapter 8)					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	-34,680	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-21,443,458			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1				12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					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					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	CRNA OFFSET	A	-30,701	Employee Benefits Department	4	33
34	CRNA OFFSET	A	-79,330	Anesthesiology	53	34
35	PATIENT PORTION OF OPERATORS TIME	A	-1,606	Employee Benefits Department	4	35
36	PATIENT PORTION OF OPERATORS TIME	A	-4,149	Administrative & General	5	36
37	ADVERTISING OFFSET	A	-1,495,331	Administrative & General	5	37
38	ADVERTISING OFFSET	A	-946	Operation of Plant	7	38
39	ADVERTISING OFFSET	A	-112	Central Services & Supply	14	39
40	ADVERTISING OFFSET	A	-34	Operating Room	50	40
41	ADVERTISING OFFSET	A	-142	Radiology-Diagnostic	54	41
42	ADVERTISING OFFSET	A	-13,420	Physical Therapy	66	42
43	ADVERTISING OFFSET	A	-350	PROVIDER BASED PHYSICIAN CLINICS	90.01	43
44	ADVERTISING OFFSET	A	-10,084	Emergency	91	44
45	ADVERTISING OFFSET	A	-1,980	Home Health Agency	101	45
46	REMOVE PHYSICIAN BENEFITS	A	-3,238,579	Employee Benefits Department	4	46
47	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-1,181,395	Cap Rel Costs-Bldg & Fixt	1	9 47
48	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-5,629,587	Employee Benefits Department	4	48
49	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-4,174,166	Administrative & General	5	49
49.01	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-467,279	Operation of Plant	7	49.01
49.02	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-15,323	Laundry & Linen Service	8	49.02
49.03	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-215,555	Housekeeping	9	49.03
49.04	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-328,630	Nursing Administration	13	49.04
49.05	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-479,751	Medical Records & Library	16	49.05
49.06	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-293,065	Radiology-Diagnostic	54	49.06
49.07	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-4,665	Laboratory	60	49.07
49.08	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-860,229	Physical Therapy	66	49.08

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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	
49.09	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-32,892	Electrocardiology	69		49.09
49.10	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-612,081	Medical Supplies Charged to Patients	71		49.10
49.11	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-1,325,669	Drugs Charged to Patients	73		49.11
49.12	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-96,371	ULTRASOUND	76.05		49.12
49.13	REMOVE ESTIMATE OF PHYSICIAN COSTS	A	-8,728,761	PROVIDER BASED PHYSICIAN CLINICS	90.01		49.13
49.14	MISC REV OFFSET	B	-604,463	Administrative & General	5		49.14
49.15	MISC REV OFFSET	B	-6,997	Operation of Plant	7		49.15
49.16	MISC REV OFFSET	B	-136	Laundry & Linen Service	8		49.16
49.17	MISC REV OFFSET	B	-4,060	Housekeeping	9		49.17
49.18	MISC REV OFFSET	B	-90	Dietary	10		49.18
49.19	MISC REV OFFSET	B	-600,090	Cafeteria	11		49.19
49.20	MISC REV OFFSET	B	-350	Nursing Administration	13		49.20
49.21	MISC REV OFFSET	B	-6,104	Pharmacy	15		49.21
49.22	MISC REV OFFSET	B	-14,437	Medical Records & Library	16		49.22
49.23	MISC REV OFFSET	B	-2,445	Adults & Pediatrics	30		49.23
49.24	MISC REV OFFSET	B	-4,238	Radiology-Diagnostic	54		49.24
49.25	MISC REV OFFSET	B	-755	Physical Therapy	66		49.25
49.26	MISC REV OFFSET	B	-78,341	PSYCH	76.04		49.26
49.27	MISC REV OFFSET	B	-864	VASCULAR LAB	76.06		49.27
49.28	MISC REV OFFSET	B	-15,222	PROVIDER BASED PHYSICIAN CLINICS	90.01		49.28
49.29	MISC REV OFFSET	B	-2,260	Home Health Agency	101		49.29
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-52,141,173				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 subscripits thereof.

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1						1	
2						2	
3						3	
4						4	
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12						5

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	Type of Business
	1	2	3	4	5	6
6						6
7						7
8						8
9						9
10						10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
	1	90.01 PROVIDER BASED PHYSI FAMILY PRACTICE	1,982,657	1,932,407	50,250	136,700	420	27,603	1,380	1
	2	90.01 PROVIDER BASED PHYSI INTERNAL MEDICI	1,962,653	1,912,653	50,000	154,100	409	30,301	1,515	2
	3	90.01 PROVIDER BASED PHYSI SURGERY	3,563,953	3,488,953	75,000	204,100	317	31,106	1,555	3
	4	90.01 PROVIDER BASED PHYSI PEDIATRICS	1,043,396	1,043,396		152,100				4
	5	90.01 PROVIDER BASED PHYSI OB/GYN	1,663,291	1,663,291		194,500				5
	6	90.01 PROVIDER BASED PHYSI ALL OTHERS	10,906,311	10,606,310	300,001	142,500	1,335	91,460	4,573	6
	7	91 Emergency ER PHYSICIANS	384,683	384,683		171,400				7
	8	76.04 PSYCH PSYCHIATRY	131,312	131,312		142,500				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
	200	TOTAL	21,638,256	21,163,005	475,251		2,481	180,470	9,023	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	90.01	PROVIDER BASED PHYSI FAMILY PRACTICE	27,593	699	44,397	1,125	29,427	20,823	1,953,230	1
2	90.01	PROVIDER BASED PHYSI INTERNAL MEDICI	31,523	803	41,282	1,052	32,156	17,844	1,930,497	2
3	90.01	PROVIDER BASED PHYSI SURGERY	46,431	977	108,387	2,281	34,364	40,636	3,529,589	3
4	90.01	PROVIDER BASED PHYSI PEDIATRICS	17,522		17,092				1,043,396	4
5	90.01	PROVIDER BASED PHYSI OB/GYN	15,610		76,887				1,663,291	5
6	90.01	PROVIDER BASED PHYSI ALL OTHERS	56,898	1,565	211,790	5,826	98,851	201,150	10,807,460	6
7	91	Emergency ER PHYSICIANS							384,683	7
8	76.04	PSYCH PSYCHIATRY	8,433		10,263				131,312	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
200		TOTAL	204,010	4,044	510,098	10,284	194,798	280,453	21,443,458	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	9,436,258	9,436,258					1
2	Cap Rel Costs-Mvble Equip	4,574,536		4,574,536				2
4	Employee Benefits Department	25,437,333			25,437,333			4
5	Administrative & General	23,821,710	2,228,057	1,718,013	3,426,969	31,194,749	31,194,749	5
6	Maintenance & Repairs							6
7	Operation of Plant	6,630,706	439,654	88,653	544,679	7,703,692	2,024,885	7
8	Laundry & Linen Service	517,140	21,709		13,325	552,174	145,137	8
9	Housekeeping	1,048,915	6,356	5,722	295,728	1,356,721	356,609	9
10	Dietary	1,337,035	63,758	9,194	264,544	1,674,531	440,144	10
11	Cafeteria	47,738	60,405	1,851	28,876	138,870	36,501	11
12	Maintenance of Personnel							12
13	Nursing Administration	849,593	25,257	65,518	334,615	1,274,983	335,124	13
14	Central Services & Supply	823,587	107,650	113,379	158,019	1,202,635	316,108	14
15	Pharmacy	1,697,627	34,128	51,376	477,466	2,260,597	594,189	15
16	Medical Records & Library	3,381,814	142,463	604	608,686	4,133,567	1,086,492	16
17	Social Service	369,754	6,915		104,677	481,346	126,520	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,048,698	587,900	72,056	1,953,250	9,661,904	2,539,593	30
31	Intensive Care Unit	1,751,667	50,221	17,977	491,913	2,311,778	607,642	31
43	Nursery	171,875			49,365	221,240	58,152	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,729,291	163,487	253,804	568,418	3,715,000	976,473	50
51	Recovery Room	389,781	17,853	7,893	109,675	525,202	138,047	51
52	Delivery Room & Labor Room	424,633			121,962	546,595	143,670	52
53	Anesthesiology	134,347	6,775	16,344	22,785	180,251	47,378	53
54	Radiology-Diagnostic	1,829,599	193,019	301,474	421,456	2,745,548	721,656	54
55	Radiology-Therapeutic	632,082	39,548	32,691	106,166	810,487	213,033	55
57	CT Scan	1,177,949	18,552	371	203,464	1,400,336	368,073	57
58	MRI	652,935	13,243	157,244	89,216	912,638	239,883	58
59	Cardiac Catheterization	1,499,877	56,200	155,183	342,477	2,053,737	539,817	59
60	Laboratory	6,707,508	203,119	143,432	816,866	7,870,925	2,068,841	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	968,481	34,785	36,257	214,530	1,254,053	329,623	65
66	Physical Therapy	1,788,222	220,539	26,677	708,810	2,744,248	721,315	66
67	Occupational Therapy	288,065	11,120	166	70,069	369,420	97,101	67
68	Speech Pathology	118,299	6,356	321	27,822	152,798	40,162	68
69	Electrocardiology	346,383	6,845	16,496	100,412	470,136	123,573	69
71	Medical Supplies Charged to Patients	9,249,183				9,249,183	2,431,111	71
73	Drugs Charged to Patients	9,686,471				9,686,471	2,546,050	73
74	Renal Dialysis	1,490,978	98,584	64,030	283,341	1,936,933	509,115	74
75	ASC (Non-Distinct Part)	418,041	110,374	7,476	117,387	653,278	171,712	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	241,031	9,444	11,501	61,469	323,445	85,016	76.01
76.02	GI	787,386	43,124	63,593	181,241	1,075,344	282,650	76.02
76.03	NUCLEAR MED	815,463	10,910	6,614	77,731	910,718	239,379	76.03
76.04	PSYCH	1,966,878	87,841	5,999	485,641	2,546,359	669,300	76.04
76.05	ULTRASOUND	393,547	21,751	68,117	110,855	594,270	156,201	76.05
76.06	VASCULAR LAB	452,291	27,883	96,604	117,026	693,804	182,364	76.06
76.07	MEDICAL OUTPATIENT	287,098	13,970	2,012	76,108	379,188	99,668	76.07
76.97	CARDIAC REHABILITATION	199,231	23,511	11,349	55,696	289,787	76,169	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	71,238				71,238	18,725	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	3,032,921	1,459,078	216,621	8,819,952	13,528,572	3,555,900	90.01
91	Emergency	4,030,045	365,936	596,694	1,018,669	6,011,344	1,580,058	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,661,211	46,882	28,810	428,772	2,165,675	569,239	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	143,416,451	7,085,202	4,472,116	24,510,128	140,035,770	28,608,398	118

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	86,914	16,372	5,341	11,163	119,790	31,486	190
194	PATHOLOGY	73,139	7,250	4,591	9,080	94,060	24,723	194
194.01	PHYSIATRY CLINIC	206,998	9,416		58,927	275,341	72,372	194.01
194.02	JANESVILLE MED CTR	193,568	70,226	20,907	47,514	332,215	87,321	194.02
194.03	OCCUPATIONAL HEALTH & WELLNESS	1,180,658	121,913	3,430	290,781	1,596,782	419,708	194.03
194.04	ASSISTED LIVING CENTERS	2,319,687	1,329,677	29,264	432,400	4,111,028	1,080,567	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	2,398,156	796,202	38,887	77,340	3,310,585	870,174	194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	149,875,571	9,436,258	4,574,536	25,437,333	149,875,571	31,194,749	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	9,728,577						7
8	Laundry & Linen Service	31,203	728,514					8
9	Housekeeping	9,136		1,722,466				9
10	Dietary	91,640		16,293	2,222,608			10
11	Cafeteria	86,821		15,436		277,628		11
12	Maintenance of Personnel							12
13	Nursing Administration	36,303		6,454		7,895	1,660,759	13
14	Central Services & Supply	154,728		27,509		7,456		14
15	Pharmacy	49,053		8,721		8,772		15
16	Medical Records & Library	204,765		36,405		23,245		16
17	Social Service	9,939		1,767		2,632		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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	845,001	305,834	150,232	1,950,163	55,700	402,512	30
31	Intensive Care Unit	72,184	38,600	12,833	272,445	10,965	79,235	31
43	Nursery					1,316	9,508	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	234,984	100,551	41,778		13,158	95,082	50
51	Recovery Room	25,661		4,562		2,193	15,847	51
52	Delivery Room & Labor Room					3,070	22,186	52
53	Anesthesiology	9,738		1,731		439	3,169	53
54	Radiology-Diagnostic	277,430	57,159	49,324		11,842		54
55	Radiology-Therapeutic	56,843		10,106		2,193		55
57	CT Scan	26,665		4,741		4,386		57
58	MRI	19,035		3,384		1,754		58
59	Cardiac Catheterization	80,777		14,361		7,017		59
60	Laboratory	291,947		51,905		26,754		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	49,997		8,889		5,702		65
66	Physical Therapy	316,986	15,858	56,357		15,789		66
67	Occupational Therapy	15,983		2,842		1,316		67
68	Speech Pathology	9,136		1,624		439		68
69	Electrocardiology	9,839		1,749		3,070		69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	141,697	25,443	25,192		8,772	63,388	74
75	ASC (Non-Distinct Part)	158,644	21,347	28,205		2,632	19,016	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	13,573		2,413		1,754	12,678	76.01
76.02	GI	61,984		11,020		4,824	34,863	76.02
76.03	NUCLEAR MED	15,682		2,788		1,754		76.03
76.04	PSYCH	126,256		22,447		9,649		76.04
76.05	ULTRASOUND	31,263		5,558		2,193		76.05
76.06	VASCULAR LAB	40,078	8,278	7,125		2,193	15,847	76.06
76.07	MEDICAL OUTPATIENT	20,079		3,570		1,754	12,678	76.07
76.97	CARDIAC REHABILITATION	33,793		6,008		1,316	9,508	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	2,097,160	28,318	372,856			621,199	90.01
91	Emergency	525,967	115,712	93,511		23,684	171,147	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	67,385		11,980			72,896	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	6,349,355	717,100	1,121,676	2,222,608	277,628	1,660,759	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	23,532		4,184				190

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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	
194	PATHOLOGY	10,421		1,853				194
194.0 1	PHYSIATRY CLINIC	13,533		2,406				194.0 1
194.0 2	JANESVILLE MED CTR	100,937		17,945				194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	175,229	11,414	31,154				194.0 3
194.0 4	ASSISTED LIVING CENTERS	1,911,172		339,786				194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	1,144,398		203,462				194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,728,577	728,514	1,722,466	2,222,608	277,628	1,660,759	202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	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	1,708,436						14
15	Pharmacy	2,300	2,923,632					15
16	Medical Records & Library			5,484,474				16
17	Social Service				622,204			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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	76,204	1,433	208,867	622,204	16,819,647		30
31	Intensive Care Unit	22,099	89	76,137		3,504,007		31
43	Nursery			22,952		313,168		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	144,699	33,899	368,476		5,724,100		50
51	Recovery Room	2,189	1	33,866		747,568		51
52	Delivery Room & Labor Room			57,352		772,873		52
53	Anesthesiology	26,714	55,962	50,947		376,329		53
54	Radiology-Diagnostic	12,502	414	173,423		4,049,298		54
55	Radiology-Therapeutic	472		84,033		1,177,167		55
57	CT Scan	2,667	5,168	337,582		2,149,618		57
58	MRI	318	2,534	175,584		1,355,130		58
59	Cardiac Catheterization	333,941	12,323	282,990		3,324,963		59
60	Laboratory	2,964		585,976		10,899,312		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,997	14,197	95,080		1,763,538		65
66	Physical Therapy	45,163	1,271	131,619		4,048,606		66
67	Occupational Therapy	141		24,914		511,717		67
68	Speech Pathology	1,715	7	3,197		209,078		68
69	Electrocardiology	1,376		61,566		671,309		69
71	Medical Supplies Charged to Patients	768,395	2,166,215	854,486		15,469,390		71
73	Drugs Charged to Patients			404,499		12,637,020		73
74	Renal Dialysis	61,500	111,561	171,835		3,055,436		74
75	ASC (Non-Distinct Part)	5,379		23,565		1,083,778		75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG			24,683		463,562		76.01
76.02	GI	27,362	6,356	166,025		1,670,428		76.02
76.03	NUCLEAR MED	1,391	43,040	102,455		1,317,207		76.03
76.04	PSYCH	291		44,372		3,418,674		76.04
76.05	ULTRASOUND	1,049	101	62,948		853,583		76.05
76.06	VASCULAR LAB	94		90,292		1,040,075		76.06
76.07	MEDICAL OUTPATIENT	10,830	447	22,845		551,059		76.07
76.97	CARDIAC REHABILITATION	380		11,187		428,148		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	36		814		90,813		76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	60,649	456,589	245,487		20,966,730		90.01
91	Emergency	76,859	934	461,924		9,061,140		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	10,524	766	22,496		2,920,961		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,706,200	2,913,307	5,484,474	622,204	133,445,432		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					178,992		190

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
194	PATHOLOGY	77				131,134		194
194.0 1	PHYSIATRY CLINIC	1				363,653		194.0 1
194.0 2	JANESVILLE MED CTR	20	98			538,536		194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	443	10,104			2,244,834		194.0 3
194.0 4	ASSISTED LIVING CENTERS	462	47			7,443,062		194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	1,233	76			5,529,928		194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,708,436	2,923,632	5,484,474	622,204	149,875,571		202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	16,819,647					30
31	Intensive Care Unit	3,504,007					31
43	Nursery	313,168					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,724,100					50
51	Recovery Room	747,568					51
52	Delivery Room & Labor Room	772,873					52
53	Anesthesiology	376,329					53
54	Radiology-Diagnostic	4,049,298					54
55	Radiology-Therapeutic	1,177,167					55
57	CT Scan	2,149,618					57
58	MRI	1,355,130					58
59	Cardiac Catheterization	3,324,963					59
60	Laboratory	10,899,312					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,763,538					65
66	Physical Therapy	4,048,606					66
67	Occupational Therapy	511,717					67
68	Speech Pathology	209,078					68
69	Electrocardiology	671,309					69
71	Medical Supplies Charged to Patients	15,469,390					71
73	Drugs Charged to Patients	12,637,020					73
74	Renal Dialysis	3,055,436					74
75	ASC (Non-Distinct Part)	1,083,778					75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	463,562					76.01
76.02	GI	1,670,428					76.02
76.03	NUCLEAR MED	1,317,207					76.03
76.04	PSYCH	3,418,674					76.04
76.05	ULTRASOUND	853,583					76.05
76.06	VASCULAR LAB	1,040,075					76.06
76.07	MEDICAL OUTPATIENT	551,059					76.07
76.97	CARDIAC REHABILITATION	428,148					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	90,813					76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PROVIDER BASED PHYSICIAN CLINICS	20,966,730					90.01
91	Emergency	9,061,140					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,920,961					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	133,445,432					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	178,992					190

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
194	PATHOLOGY	131,134					194
194.0 1	PHYSIATRY CLINIC	363,653					194.0 1
194.0 2	JANESVILLE MED CTR	538,536					194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	2,244,834					194.0 3
194.0 4	ASSISTED LIVING CENTERS	7,443,062					194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	5,529,928					194.0 5
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	149,875,571					202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	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		2,228,057	1,718,013	3,946,070	3,946,070		5
6	Maintenance & Repairs							6
7	Operation of Plant		439,654	88,653	528,307	256,140	784,447	7
8	Laundry & Linen Service		21,709		21,709	18,359	2,516	8
9	Housekeeping		6,356	5,722	12,078	45,110	737	9
10	Dietary		63,758	9,194	72,952	55,676	7,389	10
11	Cafeteria		60,405	1,851	62,256	4,617	7,001	11
12	Maintenance of Personnel							12
13	Nursing Administration		25,257	65,518	90,775	42,392	2,927	13
14	Central Services & Supply		107,650	113,379	221,029	39,986	12,476	14
15	Pharmacy		34,128	51,376	85,504	75,163	3,955	15
16	Medical Records & Library		142,463	604	143,067	137,437	16,511	16
17	Social Service		6,915		6,915	16,004	801	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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		587,900	72,056	659,956	321,249	68,135	30
31	Intensive Care Unit		50,221	17,977	68,198	76,864	5,820	31
43	Nursery					7,356		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		163,487	253,804	417,291	123,520	18,947	50
51	Recovery Room		17,853	7,893	25,746	17,462	2,069	51
52	Delivery Room & Labor Room					18,174		52
53	Anesthesiology		6,775	16,344	23,119	5,993	785	53
54	Radiology-Diagnostic		193,019	301,474	494,493	91,287	22,370	54
55	Radiology-Therapeutic		39,548	32,691	72,239	26,948	4,583	55
57	CT Scan		18,552	371	18,923	46,560	2,150	57
58	MRI		13,243	157,244	170,487	30,344	1,535	58
59	Cardiac Catheterization		56,200	155,183	211,383	68,285	6,513	59
60	Laboratory		203,119	143,432	346,551	261,700	23,541	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		34,785	36,257	71,042	41,696	4,031	65
66	Physical Therapy		220,539	26,677	247,216	91,244	25,560	66
67	Occupational Therapy		11,120	166	11,286	12,283	1,289	67
68	Speech Pathology		6,356	321	6,677	5,080	737	68
69	Electrocardiology		6,845	16,496	23,341	15,632	793	69
71	Medical Supplies Charged to Patients					307,526		71
73	Drugs Charged to Patients					322,065		73
74	Renal Dialysis		98,584	64,030	162,614	64,401	11,425	74
75	ASC (Non-Distinct Part)		110,374	7,476	117,850	21,721	12,792	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		9,444	11,501	20,945	10,754	1,094	76.01
76.02	GI		43,124	63,593	106,717	35,754	4,998	76.02
76.03	NUCLEAR MED		10,910	6,614	17,524	30,280	1,264	76.03
76.04	PSYCH		87,841	5,999	93,840	84,664	10,180	76.04
76.05	ULTRASOUND		21,751	68,117	89,868	19,759	2,521	76.05
76.06	VASCULAR LAB		27,883	96,604	124,487	23,068	3,232	76.06
76.07	MEDICAL OUTPATIENT		13,970	2,012	15,982	12,608	1,619	76.07
76.97	CARDIAC REHABILITATION		23,511	11,349	34,860	9,635	2,725	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					2,369		76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS		1,459,078	216,621	1,675,699	449,863	169,105	90.01
91	Emergency		365,936	596,694	962,630	199,871	42,410	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		46,882	28,810	75,692	72,007	5,433	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		7,085,202	4,472,116	11,557,318	3,618,906	511,969	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		16,372	5,341	21,713	3,983	1,898	190

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	
194	PATHOLOGY		7,250	4,591	11,841	3,127	840	194
194.0 1	PHYSIATRY CLINIC		9,416		9,416	9,155	1,091	194.0 1
194.0 2	JANESVILLE MED CTR		70,226	20,907	91,133	11,046	8,139	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS		121,913	3,430	125,343	53,091	14,129	194.0 3
194.0 4	ASSISTED LIVING CENTERS		1,329,677	29,264	1,358,941	136,688	154,104	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		796,202	38,887	835,089	110,074	92,277	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		9,436,258	4,574,536	14,010,794	3,946,070	784,447	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		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	42,584						8
9	Housekeeping		57,925					9
10	Dietary		548	136,565				10
11	Cafeteria		519		74,393			11
12	Maintenance of Personnel							12
13	Nursing Administration		217			138,426		13
14	Central Services & Supply		925				276,414	14
15	Pharmacy		293				372	15
16	Medical Records & Library		1,224			6,229		16
17	Social Service		59			705		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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,877	5,052	119,825	14,923	33,550	12,329	30
31	Intensive Care Unit	2,256	432	16,740	2,938	6,604	3,575	31
43	Nursery				353	793		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,878	1,405		3,526	7,925	23,411	50
51	Recovery Room		153		588	1,321	354	51
52	Delivery Room & Labor Room				823	1,849		52
53	Anesthesiology		58		118	264	4,322	53
54	Radiology-Diagnostic	3,341	1,659		3,173		2,023	54
55	Radiology-Therapeutic		340		588		76	55
57	CT Scan		159		1,175		432	57
58	MRI		114		470		51	58
59	Cardiac Catheterization		483		1,880		54,030	59
60	Laboratory		1,746		7,169		479	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		299		1,528		970	65
66	Physical Therapy	927	1,895		4,231		7,307	66
67	Occupational Therapy		96		353		23	67
68	Speech Pathology		55		118		278	68
69	Electrocardiology		59		823		223	69
71	Medical Supplies Charged to Patients						124,323	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,487	847		2,350	5,283	9,950	74
75	ASC (Non-Distinct Part)	1,248	949		705	1,585	870	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		81		470	1,057		76.01
76.02	GI		371		1,293	2,906	4,427	76.02
76.03	NUCLEAR MED		94		470		225	76.03
76.04	PSYCH		755		2,586		47	76.04
76.05	ULTRASOUND		187		588		170	76.05
76.06	VASCULAR LAB	484	240		588	1,321	15	76.06
76.07	MEDICAL OUTPATIENT		120		470	1,057	1,752	76.07
76.97	CARDIAC REHABILITATION		202		353	793	61	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY						6	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	1,655	12,537			51,777	9,813	90.01
91	Emergency	6,764	3,145		6,346	14,265	12,435	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		403			6,076	1,703	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	41,917	37,721	136,565	74,393	138,426	276,052	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		141					190

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
194	PATHOLOGY		62				12	194
194.0 1	PHYSIATRY CLINIC		81					194.0 1
194.0 2	JANESVILLE MED CTR		603				3	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	667	1,048				72	194.0 3
194.0 4	ASSISTED LIVING CENTERS		11,427				75	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		6,842				200	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,584	57,925	136,565	74,393	138,426	276,414	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	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	167,637						15
16	Medical Records & Library		304,468					16
17	Social Service			24,484				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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	82	11,604	24,484	1,289,066		1,289,066	30
31	Intensive Care Unit	5	4,230		187,662		187,662	31
43	Nursery		1,275		9,777		9,777	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,944	20,471		624,318		624,318	50
51	Recovery Room		1,881		49,574		49,574	51
52	Delivery Room & Labor Room		3,186		24,032		24,032	52
53	Anesthesiology	3,209	2,830		40,698		40,698	53
54	Radiology-Diagnostic	24	9,635		628,005		628,005	54
55	Radiology-Therapeutic		4,668		109,442		109,442	55
57	CT Scan	296	18,755		88,450		88,450	57
58	MRI	145	9,755		212,901		212,901	58
59	Cardiac Catheterization	707	15,722		359,003		359,003	59
60	Laboratory		32,554		673,740		673,740	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	814	5,282		125,662		125,662	65
66	Physical Therapy	73	7,312		385,765		385,765	66
67	Occupational Therapy		1,384		26,714		26,714	67
68	Speech Pathology		178		13,123		13,123	68
69	Electrocardiology		3,420		44,291		44,291	69
71	Medical Supplies Charged to Patients	124,207	47,249		603,305		603,305	71
73	Drugs Charged to Patients		22,472		344,537		344,537	73
74	Renal Dialysis	6,397	9,546		274,300		274,300	74
75	ASC (Non-Distinct Part)		1,309		159,029		159,029	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		1,371		35,772		35,772	76.01
76.02	GI	364	9,224		166,054		166,054	76.02
76.03	NUCLEAR MED	2,468	5,692		58,017		58,017	76.03
76.04	PSYCH		2,465		194,537		194,537	76.04
76.05	ULTRASOUND	6	3,497		116,596		116,596	76.05
76.06	VASCULAR LAB		5,016		158,451		158,451	76.06
76.07	MEDICAL OUTPATIENT	26	1,269		34,903		34,903	76.07
76.97	CARDIAC REHABILITATION		621		49,250		49,250	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		45		2,420		2,420	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	26,180	13,638		2,410,267		2,410,267	90.01
91	Emergency	54	25,662		1,273,582		1,273,582	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	44	1,250		162,608		162,608	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	167,045	304,468	24,484	10,935,851		10,935,851	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				27,735		27,735	190

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
194	PATHOLOGY				15,882		15,882	194
194.0 1	PHYSIATRY CLINIC				19,743		19,743	194.0 1
194.0 2	JANESVILLE MED CTR	6			110,930		110,930	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	579			194,929		194,929	194.0 3
194.0 4	ASSISTED LIVING CENTERS	3			1,661,238		1,661,238	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	4			1,044,486		1,044,486	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	167,637	304,468	24,484	14,010,794		14,010,794	202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT T GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	675,481						1
2	Cap Rel Costs-Mvble Equip		4,915,057					2
4	Employee Benefits Department			88,564,801				4
5	Administrative & General	159,492	1,845,898	11,931,636	-31,194,749	118,680,822		5
6	Maintenance & Repairs							6
7	Operation of Plant	31,472	95,252	1,896,403		7,703,692	484,517	7
8	Laundry & Linen Service	1,554		46,394		552,174	1,554	8
9	Housekeeping	455	6,148	1,029,632		1,356,721	455	9
10	Dietary	4,564	9,878	921,061		1,674,531	4,564	10
11	Cafeteria	4,324	1,989	100,538		138,870	4,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,808	70,395	1,165,025		1,274,983	1,808	13
14	Central Services & Supply	7,706	121,819	550,173		1,202,635	7,706	14
15	Pharmacy	2,443	55,200	1,662,386		2,260,597	2,443	15
16	Medical Records & Library	10,198	649	2,119,255		4,133,567	10,198	16
17	Social Service	495		364,452		481,346	495	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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,084	77,420	6,800,607		9,661,904	42,084	30
31	Intensive Care Unit	3,595	19,315	1,712,687		2,311,778	3,595	31
43	Nursery			171,875		221,240		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,703	272,697	1,979,054		3,715,000	11,703	50
51	Recovery Room	1,278	8,481	381,854		525,202	1,278	51
52	Delivery Room & Labor Room			424,633		546,595		52
53	Anesthesiology	485	17,561	79,330		180,251	485	53
54	Radiology-Diagnostic	13,817	323,915	1,467,380		2,745,548	13,817	54
55	Radiology-Therapeutic	2,831	35,124	369,638		810,487	2,831	55
57	CT Scan	1,328	399	708,397		1,400,336	1,328	57
58	MRI	948	168,949	310,622		912,638	948	58
59	Cardiac Catheterization	4,023	166,735	1,192,397		2,053,737	4,023	59
60	Laboratory	14,540	154,109	2,844,071		7,870,925	14,540	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,490	38,956	746,927		1,254,053	2,490	65
66	Physical Therapy	15,787	28,663	2,467,854		2,744,248	15,787	66
67	Occupational Therapy	796	178	243,960		369,420	796	67
68	Speech Pathology	455	345	96,867		152,798	455	68
69	Electrocardiology	490	17,724	349,603		470,136	490	69
71	Medical Supplies Charged to Patients					9,249,183		71
73	Drugs Charged to Patients					9,686,471		73
74	Renal Dialysis	7,057	68,796	986,504		1,936,933	7,057	74
75	ASC (Non-Distinct Part)	7,901	8,032	408,704		653,278	7,901	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	676	12,357	214,017		323,445	676	76.01
76.02	GI	3,087	68,327	631,023		1,075,344	3,087	76.02
76.03	NUCLEAR MED	781	7,106	270,635		910,718	781	76.03
76.04	PSYCH	6,288	6,446	1,690,849		2,546,359	6,288	76.04
76.05	ULTRASOUND	1,557	73,187	385,961		594,270	1,557	76.05
76.06	VASCULAR LAB	1,996	103,795	407,449		693,804	1,996	76.06
76.07	MEDICAL OUTPATIENT	1,000	2,162	264,983		379,188	1,000	76.07
76.97	CARDIAC REHABILITATION	1,683	12,194	193,915		289,787	1,683	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					71,238		76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	104,446	232,746	30,708,269		13,528,572	104,446	90.01
91	Emergency	26,195	641,111	3,546,688		6,011,344	26,195	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,356	30,955	1,492,851		2,165,675	3,356	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	507,184	4,805,013	85,336,559	-31,194,749	108,841,021	316,220	118
	NONREIMBURSABLE COST CENTERS							

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
190	Gift, Flower, Coffee Shop & Canteen	1,172	5,739	38,865		119,790	1,172	190
194	PATHOLOGY	519	4,933	31,615		94,060	519	194
194.0	PHYSIATRY CLINIC	674		205,166		275,341	674	194.0
1								1
194.0	JANESVILLE MED CTR	5,027	22,463	165,430		332,215	5,027	194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS	8,727	3,685	1,012,410		1,596,782	8,727	194.0
3								3
194.0	ASSISTED LIVING CENTERS	95,183	31,442	1,505,483		4,111,028	95,183	194.0
4								4
194.0	NORTHPOINTE FITNESS & SPA CENTER	56,995	41,782	269,273		3,310,585	56,995	194.0
5								5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	9,436,258	4,574,536	25,437,333		31,194,749	9,728,577	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.969687	0.930719	0.287217		0.262846	20.078918	203
204	Cost to be allocated (Per Wkst. B, Part II)					3,946,070	784,447	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.033249	1.619029	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINISTRATION DIRECT NRSNG 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	836,100						8
9	Housekeeping		482,508					9
10	Dietary		4,564	18,070				10
11	Cafeteria		4,324		633			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,808		18	524		13
14	Central Services & Supply		7,706		17		7,726,491	14
15	Pharmacy		2,443		20		10,400	15
16	Medical Records & Library		10,198		53			16
17	Social Service		495		6			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	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	351,000	42,084	15,855	127	127	344,637	30
31	Intensive Care Unit	44,300	3,595	2,215	25	25	99,944	31
43	Nursery				3	3		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	115,400	11,703		30	30	654,409	50
51	Recovery Room		1,278		5	5	9,900	51
52	Delivery Room & Labor Room				7	7		52
53	Anesthesiology		485		1	1	120,816	53
54	Radiology-Diagnostic	65,600	13,817		27		56,542	54
55	Radiology-Therapeutic		2,831		5		2,136	55
57	CT Scan		1,328		10		12,062	57
58	MRI		948		4		1,436	58
59	Cardiac Catheterization		4,023		16		1,510,267	59
60	Laboratory		14,540		61		13,403	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,490		13		27,124	65
66	Physical Therapy	18,200	15,787		36		204,252	66
67	Occupational Therapy		796		3		638	67
68	Speech Pathology		455		1		7,758	68
69	Electrocardiology		490		7		6,224	69
71	Medical Supplies Charged to Patients						3,475,100	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	29,200	7,057		20	20	278,135	74
75	ASC (Non-Distinct Part)	24,500	7,901		6	6	24,329	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		676		4	4		76.01
76.02	GI		3,087		11	11	123,744	76.02
76.03	NUCLEAR MED		781		4		6,289	76.03
76.04	PSYCH		6,288		22		1,314	76.04
76.05	ULTRASOUND		1,557		5		4,746	76.05
76.06	VASCULAR LAB	9,500	1,996		5	5	427	76.06
76.07	MEDICAL OUTPATIENT		1,000		4	4	48,980	76.07
76.97	CARDIAC REHABILITATION		1,683		3	3	1,717	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY						164	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	32,500	104,446			196	274,288	90.01
91	Emergency	132,800	26,195		54	54	347,600	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		3,356			23	47,595	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	823,000	314,211	18,070	633	524	7,716,376	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,172					190

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
194	PATHOLOGY		519				346	194
194.0 1	PHYSIATRY CLINIC		674				6	194.0 1
194.0 2	JANESVILLE MED CTR		5,027				91	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	13,100	8,727				2,005	194.0 3
194.0 4	ASSISTED LIVING CENTERS		95,183				2,089	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		56,995				5,578	194.0 5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	728,514	1,722,466	2,222,608	277,628	1,660,759	1,708,436	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.871324	3.569819	122.999889	438.590837	3,169.387405	0.221114	203
204	Cost to be allocated (Per Wkst. B, Part II)	42,584	57,925	136,565	74,393	138,426	276,414	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.050932	0.120050	7.557554	117.524487	264.171756	0.035775	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT				
	15	16	17				

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	11,024,222					15
16	Medical Records & Library		530,831,187				16
17	Social Service			13,749			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	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,402	20,215,531	13,749			30
31	Intensive Care Unit	337	7,369,023				31
43	Nursery		2,221,438				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	127,822	35,663,605				50
51	Recovery Room	5	3,277,741				51
52	Delivery Room & Labor Room		5,550,869				52
53	Anesthesiology	211,018	4,930,943				53
54	Radiology-Diagnostic	1,560	16,785,062				54
55	Radiology-Therapeutic		8,133,229				55
57	CT Scan	19,487	32,673,439				57
58	MRI	9,556	16,994,208				58
59	Cardiac Catheterization	46,465	27,389,627				59
60	Laboratory		56,714,714				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	53,534	9,202,443				65
66	Physical Therapy	4,794	12,738,991				66
67	Occupational Therapy		2,411,320				67
68	Speech Pathology	25	309,395				68
69	Electrocardiology		5,958,796				69
71	Medical Supplies Charged to Patients	8,168,217	82,710,273				71
73	Drugs Charged to Patients		39,150,079				73
74	Renal Dialysis	420,664	16,631,354				74
75	ASC (Non-Distinct Part)		2,280,782				75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG		2,389,017				76.01
76.02	GI	23,968	16,069,003				76.02
76.03	NUCLEAR MED	162,291	9,916,279				76.03
76.04	PSYCH		4,294,648				76.04
76.05	ULTRASOUND	379	6,092,525				76.05
76.06	VASCULAR LAB		8,739,065				76.06
76.07	MEDICAL OUTPATIENT	1,686	2,211,140				76.07
76.97	CARDIAC REHABILITATION		1,082,729				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY		78,736				76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	1,721,671	23,759,841				90.01
91	Emergency	3,520	44,708,068				91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,889	2,177,274				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,985,290	530,831,187	13,749			118

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT				
		15	16	17				
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.0	PHYSIATRY CLINIC							194.0
1								1
194.0	JANESVILLE MED CTR	369						194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS	38,099						194.0
3								3
194.0	ASSISTED LIVING CENTERS	177						194.0
4								4
194.0	NORTHPOINTE FITNESS & SPA CENTER	287						194.0
5								5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,923,632	5,484,474	622,204				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.265201	0.010332	45.254491				203
204	Cost to be allocated (Per Wkst. B, Part II)	167,637	304,468	24,484				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.015206	0.000574	1.780784				205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,819,647		16,819,647		16,819,647	30
31	Intensive Care Unit	3,504,007		3,504,007		3,504,007	31
43	Nursery	313,168		313,168		313,168	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,724,100		5,724,100		5,724,100	50
51	Recovery Room	747,568		747,568		747,568	51
52	Delivery Room & Labor Room	772,873		772,873		772,873	52
53	Anesthesiology	376,329		376,329		376,329	53
54	Radiology-Diagnostic	4,049,298		4,049,298		4,049,298	54
55	Radiology-Therapeutic	1,177,167		1,177,167		1,177,167	55
57	CT Scan	2,149,618		2,149,618		2,149,618	57
58	MRI	1,355,130		1,355,130		1,355,130	58
59	Cardiac Catheterization	3,324,963		3,324,963		3,324,963	59
60	Laboratory	10,899,312		10,899,312		10,899,312	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,763,538		1,763,538		1,763,538	65
66	Physical Therapy	4,048,606		4,048,606		4,048,606	66
67	Occupational Therapy	511,717		511,717		511,717	67
68	Speech Pathology	209,078		209,078		209,078	68
69	Electrocardiology	671,309		671,309		671,309	69
71	Medical Supplies Charged to Patients	15,469,390		15,469,390		15,469,390	71
73	Drugs Charged to Patients	12,637,020		12,637,020		12,637,020	73
74	Renal Dialysis	3,055,436		3,055,436		3,055,436	74
75	ASC (Non-Distinct Part)	1,083,778		1,083,778		1,083,778	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	463,562		463,562		463,562	76.01
76.02	GI	1,670,428		1,670,428		1,670,428	76.02
76.03	NUCLEAR MED	1,317,207		1,317,207		1,317,207	76.03
76.04	PSYCH	3,418,674		3,418,674		3,418,674	76.04
76.05	ULTRASOUND	853,583		853,583		853,583	76.05
76.06	VASCULAR LAB	1,040,075		1,040,075		1,040,075	76.06
76.07	MEDICAL OUTPATIENT	551,059		551,059		551,059	76.07
76.97	CARDIAC REHABILITATION	428,148		428,148		428,148	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	90,813		90,813		90,813	76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PROVIDER BASED PHYSICIAN CLINICS	20,966,730		20,966,730	280,453	21,247,183	90.01
91	Emergency	9,061,140		9,061,140		9,061,140	91
92	Observation Beds (Non-Distinct Part)	613,296		613,296		613,296	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,920,961		2,920,961		2,920,961	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	134,058,728		134,058,728	280,453	134,339,181	200
201	Less Observation Beds	613,296		613,296		613,296	201
202	Total (line 200 minus line 201)	133,445,432		133,445,432		133,725,885	202

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	19,545,924		19,545,924				30
31	Intensive Care Unit	7,369,023		7,369,023				31
43	Nursery	2,221,438		2,221,438				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,554,252	19,109,353	35,663,605	0.160503	0.160503	0.160503	50
51	Recovery Room	839,279	2,438,462	3,277,741	0.228074	0.228074	0.228074	51
52	Delivery Room & Labor Room	2,758,601	2,792,268	5,550,869	0.139235	0.139235	0.139235	52
53	Anesthesiology	1,724,237	3,206,706	4,930,943	0.076320	0.076320	0.076320	53
54	Radiology-Diagnostic	2,405,568	14,379,494	16,785,062	0.241244	0.241244	0.241244	54
55	Radiology-Therapeutic	205,133	7,928,096	8,133,229	0.144736	0.144736	0.144736	55
57	CT Scan	6,823,204	25,850,235	32,673,439	0.065791	0.065791	0.065791	57
58	MRI	2,542,814	14,451,394	16,994,208	0.079741	0.079741	0.079741	58
59	Cardiac Catheterization	14,335,754	13,053,873	27,389,627	0.121395	0.121395	0.121395	59
60	Laboratory	20,110,270	36,604,444	56,714,714	0.192178	0.192178	0.192178	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,097,472	2,104,971	9,202,443	0.191638	0.191638	0.191638	65
66	Physical Therapy	1,299,587	11,439,404	12,738,991	0.317812	0.317812	0.317812	66
67	Occupational Therapy	616,296	1,795,024	2,411,320	0.212214	0.212214	0.212214	67
68	Speech Pathology	62,486	246,909	309,395	0.675764	0.675764	0.675764	68
69	Electrocardiology	2,270,233	3,688,563	5,958,796	0.112658	0.112658	0.112658	69
71	Medical Supplies Charged to Patients	37,393,604	45,316,669	82,710,273	0.187031	0.187031	0.187031	71
73	Drugs Charged to Patients	21,796,855	17,353,224	39,150,079	0.322784	0.322784	0.322784	73
74	Renal Dialysis	806,220	15,825,134	16,631,354	0.183715	0.183715	0.183715	74
75	ASC (Non-Distinct Part)		2,280,782	2,280,782	0.475178	0.475178	0.475178	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	68,313	2,320,704	2,389,017	0.194039	0.194039	0.194039	76.01
76.02	GI	1,027,508	15,041,495	16,069,003	0.103953	0.103953	0.103953	76.02
76.03	NUCLEAR MED	1,202,339	8,713,940	9,916,279	0.132833	0.132833	0.132833	76.03
76.04	PSYCH		4,294,648	4,294,648	0.796031	0.796031	0.796031	76.04
76.05	ULTRASOUND	482,284	5,610,241	6,092,525	0.140103	0.140103	0.140103	76.05
76.06	VASCULAR LAB	3,143,292	5,595,773	8,739,065	0.119014	0.119014	0.119014	76.06
76.07	MEDICAL OUTPATIENT	26,911	2,184,229	2,211,140	0.249219	0.249219	0.249219	76.07
76.97	CARDIAC REHABILITATION	1,246	1,081,483	1,082,729	0.395434	0.395434	0.395434	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	5,750	72,986	78,736	1.153386	1.153386	1.153386	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS							90.01
91	Emergency	6,113,015	38,595,053	44,708,068	0.202673	0.202673	0.202673	91
92	Observation Beds (Non-Distinct Part)		669,607	669,607	0.915904	0.915904	0.915904	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,177,274	2,177,274				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	180,848,908	349,982,279	530,831,187				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	180,848,908	349,982,279	530,831,187				202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,289,066		1,289,066	16,455	78.34	8,359	654,844	30
31	Intensive Care Unit	187,662		187,662	2,215	84.72	1,107	93,785	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	9,777		9,777	1,231	7.94			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,486,505		1,486,505	19,901		9,466	748,629	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 52-0100

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	624,318	35,663,605	0.017506	5,680,313	99,440	50
51	Recovery Room	49,574	3,277,741	0.015124	294,693	4,457	51
52	Delivery Room & Labor Room	24,032	5,550,869	0.004329	46,379	201	52
53	Anesthesiology	40,698	4,930,943	0.008254	781,254	6,448	53
54	Radiology-Diagnostic	628,005	16,785,062	0.037415	1,741,205	65,147	54
55	Radiology-Therapeutic	109,442	8,133,229	0.013456			55
57	CT Scan	88,450	32,673,439	0.002707	3,729,677	10,096	57
58	MRI	212,901	16,994,208	0.012528	1,352,377	16,943	58
59	Cardiac Catheterization	359,003	27,389,627	0.013107	2,681,970	35,153	59
60	Laboratory	673,740	56,714,714	0.011879	11,539,145	137,074	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	125,662	9,202,443	0.013655	1,525,877	20,836	65
66	Physical Therapy	385,765	12,738,991	0.030282	823,054	24,924	66
67	Occupational Therapy	26,714	2,411,320	0.011079	392,354	4,347	67
68	Speech Pathology	13,123	309,395	0.042415	47,389	2,010	68
69	Electrocardiology	44,291	5,958,796	0.007433	1,967,872	14,627	69
71	Medical Supplies Charged to Patients	603,305	82,710,273	0.007294	26,279,507	191,683	71
73	Drugs Charged to Patients	344,537	39,150,079	0.008800	8,155,681	71,770	73
74	Renal Dialysis	274,300	16,631,354	0.016493	450,607	7,432	74
75	ASC (Non-Distinct Part)	159,029	2,280,782	0.069726			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	35,772	2,389,017	0.014974	41,792	626	76.01
76.02	GI	166,054	16,069,003	0.010334	734,360	7,589	76.02
76.03	NUCLEAR MED	58,017	9,916,279	0.005851	572,205	3,348	76.03
76.04	PSYCH	194,537	4,294,648	0.045298			76.04
76.05	ULTRASOUND	116,596	6,092,525	0.019138	356,147	6,816	76.05
76.06	VASCULAR LAB	158,451	8,739,065	0.018131	1,279,530	23,199	76.06
76.07	MEDICAL OUTPATIENT	34,903	2,211,140	0.015785			76.07
76.97	CARDIAC REHABILITATION	49,250	1,082,729	0.045487	329	15	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	2,420	78,736	0.030736			76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PROVIDER BASED PHYSICIAN CLINICS	2,410,267	23,759,841	0.101443			90.01
91	Emergency	1,273,582	44,708,068	0.028487	3,619,490	103,108	91
92	Observation Beds (Non-Distinct Part)	47,003	669,607	0.070195			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,333,741	499,517,528		74,093,207	857,289	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	16,455		8,359	30
31	Intensive Care Unit	2,215		1,107	31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery	1,231			43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	19,901		9,466	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 52-0100

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG							76.01
76.02	GI							76.02
76.03	NUCLEAR MED							76.03
76.04	PSYCH							76.04
76.05	ULTRASOUND							76.05
76.06	VASCULAR LAB							76.06
76.07	MEDICAL OUTPATIENT							76.07
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 52-0100

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	7	8	9	10	11	12	13
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,663,605			5,680,313		6,773,613	50
51	Recovery Room	3,277,741			294,693		264,081	51
52	Delivery Room & Labor Room	5,550,869			46,379		98,425	52
53	Anesthesiology	4,930,943			781,254		776,132	53
54	Radiology-Diagnostic	16,785,062			1,741,205		8,613,544	54
55	Radiology-Therapeutic	8,133,229						55
57	CT Scan	32,673,439			3,729,677		8,413,772	57
58	MRI	16,994,208			1,352,377		3,747,779	58
59	Cardiac Catheterization	27,389,627			2,681,970		2,300,609	59
60	Laboratory	56,714,714			11,539,145		9,636,574	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,202,443			1,525,877		395,492	65
66	Physical Therapy	12,738,991			823,054		78,512	66
67	Occupational Therapy	2,411,320			392,354			67
68	Speech Pathology	309,395			47,389			68
69	Electrocardiology	5,958,796			1,967,872		2,935,565	69
71	Medical Supplies Charged to Patients	82,710,273			26,279,507		11,778,665	71
73	Drugs Charged to Patients	39,150,079			8,155,681		12,914,889	73
74	Renal Dialysis	16,631,354			450,607		2,768	74
75	ASC (Non-Distinct Part)	2,280,782						75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	2,389,017			41,792		547,322	76.01
76.02	GI	16,069,003			734,360		4,135,751	76.02
76.03	NUCLEAR MED	9,916,279			572,205		2,985,403	76.03
76.04	PSYCH	4,294,648					782,611	76.04
76.05	ULTRASOUND	6,092,525			356,147		1,781,838	76.05
76.06	VASCULAR LAB	8,739,065			1,279,530		1,179,999	76.06
76.07	MEDICAL OUTPATIENT	2,211,140						76.07
76.97	CARDIAC REHABILITATION	1,082,729			329		556,977	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	78,736						76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	23,759,841					8,830,352	90.01
91	Emergency	44,708,068			3,619,490		5,857,537	91
92	Observation Beds (Non-Distinct Part)	669,607					246,167	92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	499,517,528			74,093,207		95,634,377	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 52-0100

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	0.160503	6,773,613			1,087,185		50	
51	Recovery Room	0.228074	264,081			60,230		51	
52	Delivery Room & Labor Room	0.139235	98,425			13,704		52	
53	Anesthesiology	0.076320	776,132			59,234		53	
54	Radiology-Diagnostic	0.241244	8,613,544			2,077,966		54	
55	Radiology-Therapeutic	0.144736						55	
57	CT Scan	0.065791	8,413,772			553,550		57	
58	MRI	0.079741	3,747,779			298,852		58	
59	Cardiac Catheterization	0.121395	2,300,609			279,282		59	
60	Laboratory	0.192178	9,636,574	14,857		1,851,938	2,855	60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	Respiratory Therapy	0.191638	395,492			75,791		65	
66	Physical Therapy	0.317812	78,512			24,952		66	
67	Occupational Therapy	0.212214						67	
68	Speech Pathology	0.675764						68	
69	Electrocardiology	0.112658	2,935,565			330,715		69	
71	Medical Supplies Charged to Patients	0.187031	11,778,665	24,289		2,202,975	4,543	71	
73	Drugs Charged to Patients	0.322784	12,914,889	5,328	215,137	4,168,720	1,720	69,443	
74	Renal Dialysis	0.183715	2,768			509		74	
75	ASC (Non-Distinct Part)	0.475178						75	
76	OTHER ANCILLARY							76	
76.01	SLEEP/EEG	0.194039	547,322			106,202		76.01	
76.02	GI	0.103953	4,135,751			429,924		76.02	
76.03	NUCLEAR MED	0.132833	2,985,403			396,560		76.03	
76.04	PSYCH	0.796031	782,611			622,983		76.04	
76.05	ULTRASOUND	0.140103	1,781,838			249,641		76.05	
76.06	VASCULAR LAB	0.119014	1,179,999			140,436		76.06	
76.07	MEDICAL OUTPATIENT	0.249219						76.07	
76.97	CARDIAC REHABILITATION	0.395434	556,977			220,248		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY	1.153386						76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	PROVIDER BASED PHYSICIAN CLINICS	0.882444	8,830,352			7,792,291		90.01	
91	Emergency	0.202673	5,857,537			1,187,165		91	
92	Observation Beds (Non-Distinct Part)	0.915904	246,167			225,465		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)		95,634,377	44,474	215,137	24,456,518	9,118	69,443	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		95,634,377	44,474	215,137	24,456,518	9,118	69,443	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,289,066		1,289,066	16,455	78.34	912	71,446	30
31	Intensive Care Unit	187,662		187,662	2,215	84.72	26	2,203	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	9,777		9,777	1,231	7.94	272	2,160	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,486,505		1,486,505	19,901		1,210	75,809	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 52-0100

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	624,318	35,663,605	0.017506	696,186	12,187	50
51	Recovery Room	49,574	3,277,741	0.015124	58,142	879	51
52	Delivery Room & Labor Room	24,032	5,550,869	0.004329	514,028	2,225	52
53	Anesthesiology	40,698	4,930,943	0.008254	106,097	876	53
54	Radiology-Diagnostic	628,005	16,785,062	0.037415	165,716	6,200	54
55	Radiology-Therapeutic	109,442	8,133,229	0.013456			55
57	CT Scan	88,450	32,673,439	0.002707	396,031	1,072	57
58	MRI	212,901	16,994,208	0.012528	106,487	1,334	58
59	Cardiac Catheterization	359,003	27,389,627	0.013107	256,219	3,358	59
60	Laboratory	673,740	56,714,714	0.011879	1,369,173	16,264	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	125,662	9,202,443	0.013655	238,035	3,250	65
66	Physical Therapy	385,765	12,738,991	0.030282	67,435	2,042	66
67	Occupational Therapy	26,714	2,411,320	0.011079	20,569	228	67
68	Speech Pathology	13,123	309,395	0.042415	3,689	156	68
69	Electrocardiology	44,291	5,958,796	0.007433	208,484	1,550	69
71	Medical Supplies Charged to Patients	603,305	82,710,273	0.007294	2,518,353	18,369	71
73	Drugs Charged to Patients	344,537	39,150,079	0.008800	1,010,954	8,896	73
74	Renal Dialysis	274,300	16,631,354	0.016493	68,980	1,138	74
75	ASC (Non-Distinct Part)	159,029	2,280,782	0.069726			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	35,772	2,389,017	0.014974	3,305	49	76.01
76.02	GI	166,054	16,069,003	0.010334	62,584	647	76.02
76.03	NUCLEAR MED	58,017	9,916,279	0.005851	76,733	449	76.03
76.04	PSYCH	194,537	4,294,648	0.045298			76.04
76.05	ULTRASOUND	116,596	6,092,525	0.019138	83,947	1,607	76.05
76.06	VASCULAR LAB	158,451	8,739,065	0.018131	76,596	1,389	76.06
76.07	MEDICAL OUTPATIENT	34,903	2,211,140	0.015785			76.07
76.97	CARDIAC REHABILITATION	49,250	1,082,729	0.045487			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	2,420	78,736	0.030736			76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PROVIDER BASED PHYSICIAN CLINICS	2,410,267	23,759,841	0.101443			90.01
91	Emergency	1,273,582	44,708,068	0.028487	383,800	10,933	91
92	Observation Beds (Non-Distinct Part)	47,003	669,607	0.070195			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	9,333,741	499,517,528		8,491,543	95,098	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	16,455		912	30
31	Intensive Care Unit	2,215		26	31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery	1,231		272	43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	19,901		1,210	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 52-0100

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG							76.01
76.02	GI							76.02
76.03	NUCLEAR MED							76.03
76.04	PSYCH							76.04
76.05	ULTRASOUND							76.05
76.06	VASCULAR LAB							76.06
76.07	MEDICAL OUTPATIENT							76.07
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 52-0100

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	7	8	9	10	11	12	13
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,663,605			696,186			50
51	Recovery Room	3,277,741			58,142			51
52	Delivery Room & Labor Room	5,550,869			514,028			52
53	Anesthesiology	4,930,943			106,097			53
54	Radiology-Diagnostic	16,785,062			165,716			54
55	Radiology-Therapeutic	8,133,229						55
57	CT Scan	32,673,439			396,031			57
58	MRI	16,994,208			106,487			58
59	Cardiac Catheterization	27,389,627			256,219			59
60	Laboratory	56,714,714			1,369,173			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,202,443			238,035			65
66	Physical Therapy	12,738,991			67,435			66
67	Occupational Therapy	2,411,320			20,569			67
68	Speech Pathology	309,395			3,689			68
69	Electrocardiology	5,958,796			208,484			69
71	Medical Supplies Charged to Patients	82,710,273			2,518,353			71
73	Drugs Charged to Patients	39,150,079			1,010,954			73
74	Renal Dialysis	16,631,354			68,980			74
75	ASC (Non-Distinct Part)	2,280,782						75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	2,389,017			3,305			76.01
76.02	GI	16,069,003			62,584			76.02
76.03	NUCLEAR MED	9,916,279			76,733			76.03
76.04	PSYCH	4,294,648						76.04
76.05	ULTRASOUND	6,092,525			83,947			76.05
76.06	VASCULAR LAB	8,739,065			76,596			76.06
76.07	MEDICAL OUTPATIENT	2,211,140						76.07
76.97	CARDIAC REHABILITATION	1,082,729						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	78,736						76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PROVIDER BASED PHYSICIAN CLINICS	23,759,841						90.01
91	Emergency	44,708,068			383,800			91
92	Observation Beds (Non-Distinct Part)	669,607						92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	499,517,528			8,491,543			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 52-0100

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.160503		1,182,183		189,744	50	
51	Recovery Room	0.228074		91,234		20,808	51	
52	Delivery Room & Labor Room	0.139235		301,693		42,006	52	
53	Anesthesiology	0.076320		151,917		11,594	53	
54	Radiology-Diagnostic	0.241244		1,339,782		323,214	54	
55	Radiology-Therapeutic	0.144736					55	
57	CT Scan	0.065791		2,181,118		143,498	57	
58	MRI	0.079741		931,855		74,307	58	
59	Cardiac Catheterization	0.121395		190,877		23,172	59	
60	Laboratory	0.192178		4,058,810		780,014	60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30	
65	Respiratory Therapy	0.191638		140,948		27,011	65	
66	Physical Therapy	0.317812		352,922		112,163	66	
67	Occupational Therapy	0.212214		57,813		12,269	67	
68	Speech Pathology	0.675764		24,488		16,548	68	
69	Electrocardiology	0.112658		407,307		45,886	69	
71	Medical Supplies Charged to Patients	0.187031		2,037,692		381,112	71	
73	Drugs Charged to Patients	0.322784		1,943,567		627,352	73	
74	Renal Dialysis	0.183715		453,504		83,315	74	
75	ASC (Non-Distinct Part)	0.475178					75	
76	OTHER ANCILLARY						76	
76.01	SLEEP/EEG	0.194039		79,990		15,521	76.01	
76.02	GI	0.103953		470,801		48,941	76.02	
76.03	NUCLEAR MED	0.132833		290,371		38,571	76.03	
76.04	PSYCH	0.796031		1,183,953		942,463	76.04	
76.05	ULTRASOUND	0.140103		855,634		119,877	76.05	
76.06	VASCULAR LAB	0.119014		104,752		12,467	76.06	
76.07	MEDICAL OUTPATIENT	0.249219					76.07	
76.97	CARDIAC REHABILITATION	0.395434		14,069		5,563	76.97	
76.98	HYPERBARIC OXYGEN THERAPY						76.98	
76.99	LITHOTRIPSY	1.153386					76.99	
OUTPATIENT SERVICE COST CENTERS								
90.01	PROVIDER BASED PHYSICIAN CLINICS	0.882444					90.01	
91	Emergency	0.202673		4,313,118		874,153	91	
92	Observation Beds (Non-Distinct Part)	0.915904		63,192		57,878	92	
OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			23,223,590		5,029,447	200	
201	Less PBP Clinic Lab. Services-Program Only Charges						201	
202	Net Charges (line 200 - line 201)			23,223,590		5,029,447	202	

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,455	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,455	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)	15,855	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,359	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	16,819,647	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,819,647	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,819,647	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,022.16	38
39	Program general inpatient routine service cost (line 9 x line 38)						8,544,235	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)						8,544,235	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	3,504,007	2,215	1,581.94	1,107	1,751,208		43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						13,979,126	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						24,274,569	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						748,629	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						857,289	51
52	Total Program excludable cost (sum of lines 50 and 51)						1,605,918	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						22,668,651	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					600	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,022.16	88
89	Observation bed cost (line 87 x line 88) (see instructions)					613,296	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,289,066	16,819,647	0.076640	613,296	47,003	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,455	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,455	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)	15,855	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	912	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,231	15
16	Nursery days (title V or XIX only)	272	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)	16,819,647	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,819,647	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 35 x line 31)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,819,647	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,022.16	38	
39	Program general inpatient routine service cost (line 9 x line 38)					932,210	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)					932,210	41	
42	Nursery (Titles V and XIX only)	313,168	1,231	254.40	272	69,197	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	3,504,007	2,215	1,581.94	26	41,130	43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,596,822	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,639,359	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					75,809	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					95,098	51
52	Total Program excludable cost (sum of lines 50 and 51)					170,907	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					600	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 52-0100

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		11,291,968		30
31	Intensive Care Unit		4,482,436		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.160503	5,680,313	911,707	50
51	Recovery Room	0.228074	294,693	67,212	51
52	Delivery Room & Labor Room	0.139235	46,379	6,458	52
53	Anesthesiology	0.076320	781,254	59,625	53
54	Radiology-Diagnostic	0.241244	1,741,205	420,055	54
55	Radiology-Therapeutic	0.144736			55
57	CT Scan	0.065791	3,729,677	245,379	57
58	MRI	0.079741	1,352,377	107,840	58
59	Cardiac Catheterization	0.121395	2,681,970	325,578	59
60	Laboratory	0.192178	11,539,145	2,217,570	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.191638	1,525,877	292,416	65
66	Physical Therapy	0.317812	823,054	261,576	66
67	Occupational Therapy	0.212214	392,354	83,263	67
68	Speech Pathology	0.675764	47,389	32,024	68
69	Electrocardiology	0.112658	1,967,872	221,697	69
71	Medical Supplies Charged to Patients	0.187031	26,279,507	4,915,082	71
73	Drugs Charged to Patients	0.322784	8,155,681	2,632,523	73
74	Renal Dialysis	0.183715	450,607	82,783	74
75	ASC (Non-Distinct Part)	0.475178			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.194039	41,792	8,109	76.01
76.02	GI	0.103953	734,360	76,339	76.02
76.03	NUCLEAR MED	0.132833	572,205	76,008	76.03
76.04	PSYCH	0.796031			76.04
76.05	ULTRASOUND	0.140103	356,147	49,897	76.05
76.06	VASCULAR LAB	0.119014	1,279,530	152,282	76.06
76.07	MEDICAL OUTPATIENT	0.249219			76.07
76.97	CARDIAC REHABILITATION	0.395434	329	130	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	1.153386			76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PROVIDER BASED PHYSICIAN CLINICS	0.894248			90.01
91	Emergency	0.202673	3,619,490	733,573	91
92	Observation Beds (Non-Distinct Part)	0.915904			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		74,093,207	13,979,126	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		74,093,207		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 52-0100

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,930,021		30
31	Intensive Care Unit		489,884		31
43	Nursery		13,976		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.160503	696,186	111,740	50
51	Recovery Room	0.228074	58,142	13,261	51
52	Delivery Room & Labor Room	0.139235	514,028	71,571	52
53	Anesthesiology	0.076320	106,097	8,097	53
54	Radiology-Diagnostic	0.241244	165,716	39,978	54
55	Radiology-Therapeutic	0.144736			55
57	CT Scan	0.065791	396,031	26,055	57
58	MRI	0.079741	106,487	8,491	58
59	Cardiac Catheterization	0.121395	256,219	31,104	59
60	Laboratory	0.192178	1,369,173	263,125	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.191638	238,035	45,617	65
66	Physical Therapy	0.317812	67,435	21,432	66
67	Occupational Therapy	0.212214	20,569	4,365	67
68	Speech Pathology	0.675764	3,689	2,493	68
69	Electrocardiology	0.112658	208,484	23,487	69
71	Medical Supplies Charged to Patients	0.187031	2,518,353	471,010	71
73	Drugs Charged to Patients	0.322784	1,010,954	326,320	73
74	Renal Dialysis	0.183715	68,980	12,673	74
75	ASC (Non-Distinct Part)	0.475178			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.194039	3,305	641	76.01
76.02	GI	0.103953	62,584	6,506	76.02
76.03	NUCLEAR MED	0.132833	76,733	10,193	76.03
76.04	PSYCH	0.796031			76.04
76.05	ULTRASOUND	0.140103	83,947	11,761	76.05
76.06	VASCULAR LAB	0.119014	76,596	9,116	76.06
76.07	MEDICAL OUTPATIENT	0.249219			76.07
76.97	CARDIAC REHABILITATION	0.395434			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	1.153386			76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PROVIDER BASED PHYSICIAN CLINICS	0.882444			90.01
91	Emergency	0.202673	383,800	77,786	91
92	Observation Beds (Non-Distinct Part)	0.915904			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		8,491,543	1,596,822	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		8,491,543		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	10,254,576			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,763,978			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,674,028			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	101.36			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0615			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1760			31
32	Sum of lines 30 and 31	0.2375			32
33	Allowable disproportionate share percentage (see instructions)	0.0881			33
34	Disproportionate share adjustment (see instructions)	308,759			34
		Prior to	On or after		
		October 1	October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885		35
35.01	Factor 3 (see instructions)	0.000114083	0.000102235		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,032,038	781,857		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	771,908	197,071		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	968,979			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	16,970,320			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	16,970,320			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,270,122			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	18,240,442			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	18,240,442			61
62	Deductibles billed to program beneficiaries	1,758,624			62
63	Coinsurance billed to program beneficiaries	15,200			63
64	Allowable bad debts (see instructions)	299,528			64
65	Adjusted reimbursable bad debts (see instructions)	194,693			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	294,760			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,661,311			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-11,712			70.93
70.94	HRR adjustment amount (see instructions)	-753			70.94
71	Amount due provider (see instructions)	16,648,846			71
71.01	Sequestration adjustment (see instructions)	332,977			71.01
72	Interim payments	16,089,694			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	226,175			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2				75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

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

HSP Bonus Payment Amount

		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100

HVBP Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102

HRR Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)	0.0000	0.0000	103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 52-0100

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	78,561			1
2	Medical and other services reimbursed under OPPS (see instructions)	24,456,518			2
3	PPS payments	20,702,611			3
4	Outlier payment (see instructions)	221,053			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.872			5
6	Line 2 times line 5	21,326,084			6
7	Sum of line 3 and line 4 divided by line 6	0.9811			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	78,561			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	259,611			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	259,611			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)	259,611			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	181,050			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)	78,561			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	20,923,664			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,609,802			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	16,392,423			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)	16,392,423			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	16,392,423			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)	3,067			34
35	Adjusted reimbursable bad debts (see instructions)	1,994			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	16,394,417			37
38	MSP-LCC reconciliation amount from PS&R	7,132			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	16,387,285			40
40.01	Sequestration adjustment (see instructions)	327,746			40.01
41	Interim payments	15,980,528			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	79,011			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 52-0100

**WORKSHEET E-1
PART I**

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		16,089,694		15,980,528	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,089,694		15,980,528	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**WORKSHEET E-1
PART II**

Check Hospital CAH
applicable box:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,143	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,466	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	2,114	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	18,070	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	530,831,187	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	12,727,496	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	1,279,779	8
9	Sequestration adjustment amount (see instructions)	25,596	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,254,183	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	1,216,043	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	38,140	32

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 52-0100

**WORKSHEET E-3
PART VII**

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	2,639,359		1
2		5,029,447	2
3			3
4	2,639,359	5,029,447	4
5			5
6			6
7	2,639,359	5,029,447	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9	8,491,543	23,223,590	9
10			10
11			11
12	8,491,543	23,223,590	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	8,491,543	23,223,590	16
17	5,852,184	18,194,143	17
18			18
19			19
20			20
21	2,639,359	5,029,447	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	2,639,359	5,029,447	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	2,639,359	5,029,447	31
32			32
33			33
34			34
35			35
36	2,639,359	5,029,447	36
37			37
38	2,639,359	5,029,447	38
39			39
40	2,639,359	5,029,447	40
41	3,339,528	4,331,519	41
42	-700,169	697,928	42
43			43

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	30,196,965				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	39,919,177				4
5	Other receivables	1,840,844				5
6	Allowances for uncollectible notes and accounts receivable	-17,644,000				6
7	Inventory	3,794,628				7
8	Prepaid expenses	912,074				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	59,019,688				11
FIXED ASSETS						
12	Land	8,100,877				12
13	Land improvements	6,300,943				13
14	Accumulated depreciation	-4,113,095				14
15	Buildings	117,774,167				15
16	Accumulated depreciation	-44,428,166				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	36,366,115				19
20	Accumulated depreciation	-18,325,217				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	57,029,736				23
24	Accumulated depreciation	-45,907,560				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)	112,797,800				30
OTHER ASSETS						
31	Investments	57,623,931				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,276,258				34
35	Total other assets (sum of lines 31-34)	61,900,189				35
36	Total assets (sum of lines 11, 30 and 35)	233,717,677				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	6,156,091				37
38	Salaries, wages and fees payable	7,378,756				38
39	Payroll taxes payable	231,078				39
40	Notes and loans payable (short term)	2,647,454				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	11,611,606				44
45	Total current liabilities (sum of lines 37 thru 44)	28,024,985				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	73,957,509				47
48	Unsecured loans					48
49	Other long term liabilities	19,499,763				49
50	Total long term liabilities (sum of lines 46 thru 49)	93,457,272				50
51	Total liabilities (sum of lines 45 and 50)	121,482,257				51
CAPITAL ACCOUNTS						
52	General fund balance	112,235,420				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	112,235,420				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	233,717,677				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		116,550,238			1
2	Net income (loss) (from Worksheet G-3, line 29)		9,263,867			2
3	Total (sum of line 1 and line 2)		125,814,105			3
4	Additions (credit adjustments) (specify)					4
5	ASSETS RELEASED FROM RESTRICTIONS	1,197,922				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		1,197,922			10
11	Subtotal (line 3 plus line 10)		127,012,027			11
12	Deductions (debit adjustments) (specify)					12
13	CHANGE IN UNREALIZED GAINS / LOSSES	2,574,381				13
14	CHANGE IN SWAP VALUE	2,389,552				14
15	CHANGE IN PENSION OBLIGATION	9,761,821				15
16	FOUNDATION RECEIVABLE WRITEDOWN	50,853				16
17						17
18	Total deductions (sum of lines 12-17)		14,776,607			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		112,235,420			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	ASSETS RELEASED FROM RESTRICTIONS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	CHANGE IN UNREALIZED GAINS / LOSSES					13
14	CHANGE IN SWAP VALUE					14
15	CHANGE IN PENSION OBLIGATION					15
16	FOUNDATION RECEIVABLE WRITEDOWN					16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	41,436,968		41,436,968	1
2	Subprovider IPF				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)	41,436,968		41,436,968	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	13,369,023		13,369,023	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,369,023		13,369,023	16
17	Total inpatient routine care services (sum of lines 10 and 16)	54,805,991		54,805,991	17
18	Ancillary services	126,230,882	472,804,466	599,035,348	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		2,177,274	2,177,274	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)	181,036,873	474,981,740	656,018,613	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		202,016,744	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				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		202,016,744	43

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	656,018,613	1
2	Less contractual allowances and discounts on patients' accounts	456,133,480	2
3	Net patient revenues (line 1 minus line 2)	199,885,133	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	202,016,744	4
5	Net income from service to patients (line 3 minus line 4)	-2,131,611	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	9,059,288	24
24.0	Other (NON OPERATING INCOME - NET)	2,336,190	24.0
1			1
25	Total other income (sum of lines 6-24)	11,395,478	25
26	Total (line 5 plus line 25)	9,263,867	26
29	Net income (or loss) for the period (line 26 minus line 28)	9,263,867	29

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 52-7075

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	255,892			107,875		5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	769,668		40,366			6
7	Physical Therapy	287,130		15,059			7
8	Occupational Therapy	112,093		5,879			8
9	Speech Pathology	965					9
10	Medical Social Services	1,866					10
11	Home Health Aide	65,237		3,421			11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	1,492,851		64,725	107,875		24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 52-7075

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENT S	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	363,767		363,767	-4,240	359,527	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	810,034		810,034		810,034	6
7	Physical Therapy	302,189		302,189		302,189	7
8	Occupational Therapy	117,972		117,972		117,972	8
9	Speech Pathology	965		965		965	9
10	Medical Social Services	1,866		1,866		1,866	10
11	Home Health Aide	68,658		68,658		68,658	11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	1,665,451		1,665,451	-4,240	1,661,211	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 52-7075

**WORKSHEET H-1
PART I**

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANC E	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	359,527				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	810,034				6
7	Physical Therapy	302,189				7
8	Occupational Therapy	117,972				8
9	Speech Pathology	965				9
10	Medical Social Services	1,866				10
11	Home Health Aide	68,658				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	1,661,211				24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 52-7075

**WORKSHEET H-1
PART I**

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		359,527	359,527		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		810,034	223,733	1,033,767	6
7	Physical Therapy		302,189	83,465	385,654	7
8	Occupational Therapy		117,972	32,584	150,556	8
9	Speech Pathology		965	267	1,232	9
10	Medical Social Services		1,866	515	2,381	10
11	Home Health Aide		68,658	18,963	87,621	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		1,661,211		1,661,211	24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 52-7075

**WORKSHEET H-1
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures	3,356						1
2	Capital Related-Movable Equipment		57,299					2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General	3,356	57,299			-359,527	1,301,684	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						810,034	6
7	Physical Therapy						302,189	7
8	Occupational Therapy						117,972	8
9	Speech Pathology						965	9
10	Medical Social Services						1,866	10
11	Home Health Aide						68,658	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)	3,356	57,299			-359,527	1,301,684	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						359,527	25
26	Unit Cost Multiplier						0.276201	26

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 52-7075

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols.0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	
1	Administrative and General	0	46,882	28,810	73,497	149,189	39,214	1
2	Skilled Nursing Care	1,033,767			221,061	1,254,828	329,826	2
3	Physical Therapy	385,654			82,469	468,123	123,044	3
4	Occupational Therapy	150,556			32,195	182,751	48,035	4
5	Speech Pathology	1,232			277	1,509	397	5
6	Medical Social Services	2,381			536	2,917	767	6
7	Home Health Aide	87,621			18,737	106,358	27,956	7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	1,661,211	46,882	28,810	428,772	2,165,675	569,239	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 52-7075

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	
1	Administrative and General		67,385		11,980			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		67,385		11,980			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 52-7075

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
1	Administrative and General		72,896	10,524	766	22,496		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		72,896	10,524	766	22,496		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 52-7075

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						374,450	1
2	Skilled Nursing Care						1,584,654	2
3	Physical Therapy						591,167	3
4	Occupational Therapy						230,786	4
5	Speech Pathology						1,906	5
6	Medical Social Services						3,684	6
7	Home Health Aide						134,314	7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)						2,920,961	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 52-7075

**WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS		
		25	26	27	28		
1	Administrative and General		374,450				1
2	Skilled Nursing Care		1,584,654	233,014	1,817,668		2
3	Physical Therapy		591,167	86,928	678,095		3
4	Occupational Therapy		230,786	33,936	264,722		4
5	Speech Pathology		1,906	280	2,186		5
6	Medical Social Services		3,684	542	4,226		6
7	Home Health Aide		134,314	19,750	154,064		7
8	Supplies						8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing						13
14	Clinic						14
15	Health Promotion Activities						15
16	Day Care Program						16
17	Home Delivered Meals Program						17
18	Homemaker Service						18
19	All Others						19
20	Totals (sum of lines 1-19)(2)		2,920,961	374,450	2,920,961		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.147044			21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 52-7075

**WORKSHEET H-2
PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	Administrative and General	3,356	30,955	255,892		149,189		1
2	Skilled Nursing Care			769,668		1,254,828		2
3	Physical Therapy			287,130		468,123		3
4	Occupational Therapy			112,093		182,751		4
5	Speech Pathology			965		1,509		5
6	Medical Social Services			1,866		2,917		6
7	Home Health Aide			65,237		106,358		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	3,356	30,955	1,492,851		2,165,675		20
21	Total cost to be allocated	46,882	28,810	428,772		569,239		21
22	Unit Cost Multiplier	13.969607		0.287217		0.262846		22
22	Unit Cost Multiplier		0.930706					22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 52-7075

**WORKSHEET H-2
PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	3,356		3,356				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	3,356		3,356				20
21	Total cost to be allocated	67,385		11,980				21
22	Unit Cost Multiplier	20.078963		3.569726				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 52-7075

**WORKSHEET H-2
PART II**

	HHA COST CENTER	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	23	47,595	2,889	2,177,274			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	23	47,595	2,889	2,177,274			20
21	Total cost to be allocated	72,896	10,524	766	22,496			21
22	Unit Cost Multiplier	3,169.391304		0.265144				22
22	Unit Cost Multiplier		0.221116		0.010332			22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 52-7075

**WORKSHEET H-2
PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME		
		20	21	22	23		
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Home Health Aide						7
8	Supplies						8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing						13
14	Clinic						14
15	Health Promotion Activities						15
16	Day Care Program						16
17	Home Delivered Meals Program						17
18	Homemaker Service						18
19	All Others						19
19.50	Telemedicine						19.50
20	Totals (sum of lines 1-19)						20
21	Total cost to be allocated						21
22	Unit Cost Multiplier						22
22	Unit Cost Multiplier						22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

**WORKSHEET H-3
PARTS I & II**

Check applicable box: [] Title V [XX] Title XVIII [] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	1,817,668		1,817,668	7,611	238.82	1
2	Physical Therapy	3	678,095		678,095	2,767	245.07	2
3	Occupational Therapy	4	264,722		264,722	1,028	257.51	3
4	Speech Pathology	5	2,186		2,186	14	156.14	4
5	Medical Social Services	6	4,226		4,226	31	136.32	5
6	Home Health Aide	7	154,064		154,064	1,739	88.59	6
7	Total (sum of lines 1-6)		2,920,961		2,920,961	13,190		7

Limitation Cost Computation						
	Patient Services	CBSA No.	Part A	Program Visits		
				PART B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	27500		4,890		8
8.01	Skilled Nursing Care	40420		561		8.01
8.02	Skilled Nursing Care	99952		20		8.02
9	Physical Therapy	27500		1,697		9
9.01	Physical Therapy	40420		175		9.01
9.02	Physical Therapy	99952				9.02
10	Occupational Therapy	27500		683		10
10.01	Occupational Therapy	40420		109		10.01
10.02	Occupational Therapy	99952				10.02
11	Speech Pathology	27500		1		11
11.01	Speech Pathology	40420		11		11.01
11.02	Speech Pathology	99952				11.02
12	Medical Social Services	27500		21		12
12.01	Medical Social Services	40420		3		12.01
12.02	Medical Social Services	99952				12.02
13	Home Health Aide	27500		1,309		13
13.01	Home Health Aide	40420		270		13.01
13.02	Home Health Aide	99952				13.02
14	Total (sum of lines 8-13)			9,750		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8				486		15
16	Cost of Drugs	9				1,084		16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.317812			col. 2, line 2	1
2	Occupational Therapy	67	0.212214			col. 2, line 3	2

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

**WORKSHEET H-3
PARTS I & II**

Check applicable box: Title V Title XVIII Title XIX

3	Speech Pathology	68	0.675764		col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.187031		col. 2, line 15	4
5	Drugs Charged to Patients	73	0.322784		col. 2, line 16	5

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

WORKSHEET H-3
PARTS I & II

Check applicable box: [] Title V [XX] Title XVIII [] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B				
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		5,471			1,306,584		1,306,584	1
2	Physical Therapy		1,872			458,771		458,771	2
3	Occupational Therapy		792			203,948		203,948	3
4	Speech Pathology		12			1,874		1,874	4
5	Medical Social Services		24			3,272		3,272	5
6	Home Health Aide		1,579			139,884		139,884	6
7	Total (sum of lines 1-6)		9,750			2,114,333		2,114,333	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
		Part B			Part B			
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 52-7075

**WORKSHEET H-4
PARTS I & II**

Check applicable box: [] Title V [XX] Title XVIII [] Title XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	Description	Part A 1	Part B		
			Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount 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(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services 1	Part B Services 2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		1,157,127	11
12	Total PPS Reimbursement - Full Episodes with Outliers		67,620	12
13	Total PPS Reimbursement - LUPA Episodes		35,333	13
14	Total PPS Reimbursement - PEP Episodes		6,556	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		10,976	15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		1,277,612	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,277,612	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,277,612	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,277,612	29
30	Other adjustments (see instructions) (specify)		-41	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,277,571	31
31.01	Sequestration adjustment (see instructions)		25,552	31.01
32	Interim payments (see instructions)		1,253,436	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		-1,417	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA CCN: 52-7075

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider				1,253,436	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1,253,436	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

WORKSHEET I-1

Check applicable box: Renal Dialysis Department Home Program Dialysis

		TOTAL COSTS	BASIS	STATISTICS	FTEs per 2080 Hours	
		1	2	3	4	
1	Registered Nurses	424,005	Hours of Service	12,185.00	5.86	1
2	Licensed Practical Nurses	50,735	Hours of Service	2,411.00	1.16	2
3	Nurses Aides		Hours of Service			3
4	Technicians	383,335	Hours of Service	22,287.00	10.71	4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary	128,429	Accumulated Cost			8
9	Subtotal (sum of lines 1-8)	986,504				9
10	Employee Benefits		Salary			10
11	Capital Related Costs-Bldgs. & Fixtures		Square Feet			11
12	Capital Related Costs-Mov. Equip.		Percentage of Time			12
13	Machine Costs & Repairs	180,649	Percentage of Time			13
14	Supplies	153,353	Requisitions			14
15	Drugs		Requisitions			15
16	Other	170,472	Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*	1,490,978				17
18	Capital Related Costs-Bldgs. & Fixtures	98,584	Square Feet			18
19	Capital Related Costs-Mov. Equip.	64,030	Percentage of Time			19
20	Employee Benefits Department	283,341	Salary			20
21	Administrative and General	509,115	Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping	166,889	Square Feet			22
23	Medical Educatino Program Costs					23
24	Central Services & Supplies	61,500	Requisitions			24
25	Pharmacy	111,561	Requisitions			25
26	Other Allocated Costs	269,438	Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*	3,055,436				27
28	Laboratory		Charges			28
29	Respiratory Therapy		Charges			29
30	OTHER ANCILLARY		Charges			30
30.01	SLEEP/EEG		Charges			30.01
30.02	GI		Charges			30.02
30.03	NUCLEAR MED		Charges			30.03
30.04	PSYCH		Charges			30.04
30.05	ULTRASOUND		Charges			30.05
30.06	VASCULAR LAB		Charges			30.06
30.07	MEDICAL OUTPATIENT		Charges			30.07
30.97	CARDIAC REHABILITATION		Charges			30.97
30.98	HYPERBARIC OXYGEN THERAPY		Charges			30.98
30.99	LITHOTRIPSY		Charges			30.99
31	Total costs (sum of lines 27-30)	3,055,436				31

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 26 for line 74 or line 94 as appropriate.

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

WORKSHEET I-2

Check applicable box: Renal Dialysis Department Home Program Dialysis

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT	DRUGS	
		BUILDING	EQUIPMENT	RNs	OTHER			
		1	2	3	4	5	6	
1	Total Renal Department Costs	265,473	244,679	424,005	434,070	283,341	111,561	1
	MAINTENANCE							
2	Hemodialysis	199,353	183,745	318,395	325,975	212,778	83,778	2
3	Intermittent Peritoneal							3
	TRAINING							
4	Hemodialysis							4
5	Intermittent Peritoneal							5
6	CAPD	276	238	418	420	277	109	6
7	CCPD	750	683	1,183	1,214	790	311	7
	HOME							
8	Hemodialysis							8
9	Intermittent Peritoneal							9
10	CAPD	987	903	1,566	1,604	1,046	412	10
11	CCPD	58,301	53,747	93,152	95,341	62,239	24,506	11
	OTHER BILLABLE SERVICES							
12	Inpatient Dialysis	5,806	5,363	9,291	9,516	6,211	2,445	12
13	Method II Home Patient							13
14	EPO (included in renal department)							14
15	ARANESP (included in renal department)							15
16	Other							16
17	Total (sum of lines 2 through 16)	265,473	244,679	424,005	434,070	283,341	111,561	17
18	Medical Educational Program Costs							18
19	Total Renal Costs (line 17 + line 18)							19

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

WORKSHEET I-2

Check applicable box: Renal Dialysis Department Home Program Dialysis

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
		7	8	9	10	11	
1	Total Renal Department Costs	214,853		1,977,982	1,077,454	3,055,436	1
	MAINTENANCE						
2	Hemodialysis	161,346		1,485,370	809,118	2,294,488	2
3	Intermittent Peritoneal TRAINING						3
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	210		1,948	1,061	3,009	6
7	CCPD	599		5,530	3,012	8,542	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	793		7,311	3,982	11,293	10
11	CCPD	47,195		434,481	236,672	671,153	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis	4,710		43,342	23,609	66,951	12
13	Method II Home Patient						13
14	EPO (included in renal department)						14
15	ARANESP (included in renal department)						15
16	Other						16
17	Total (sum of lines 2 through 16)	214,853		1,977,982	1,077,454	3,055,436	17
18	Medical Educational Program Costs						18
19	Total Renal Costs (line 17 + line 18)					3,055,436	19

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

WORKSHEET I-3

Check applicable box: Renal Dialysis Department Home Program Dialysis

	COMPOSITE PAYMENT SERVICES	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT (Salary)	
		BUILDING (Square Feet)	EQUIPMENT (% of Time)	RNs (Hours)	OTHERS (Hours)		
		1	2	3	4	5	
1	Total Renal Department Costs	265,473	244,679	424,005	434,070	283,341	1
	MAINTENANCE						
2	Hemodialysis	5,047	51,663.00	9,150.00	21,752.00	740,825	2
3	Intermittent Peritoneal TRAINING						3
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	7	67.00	12.00	28.00	966	6
7	CCPD	19	192.00	34.00	81.00	2,750	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	25	254.00	45.00	107.00	3,641	10
11	CCPD	1,476	15,112.00	2,677.00	6,362.00	216,696	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments	147	1,508.00	267.00	635.00	21,625	12
13	Method II Home Patient						13
14	EPO						14
15	ARANESP						15
16	Other						16
17	Total Statistical Basis	6,721	68,796.00	12,185.00	28,965.00	986,503	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	39.499033	3.556588	34.797292	14.986018	0.287218	18

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

WORKSHEET I-3

Check applicable box: Renal Dialysis Department Home Program Dialysis

	COMPOSITE PAYMENT SERVICES	DRUGS (Requist.)	MEDICAL SUPPLIES (Requist.)	ROUTINE ANCILLARY SERVICES (Charges)	SUBTOTAL	OVERHEAD (Accum. Cost)	
		6	7	8	9	10	
1	Total Renal Department Costs	111,561	214,853				1
	MAINTENANCE						
2	Hemodialysis	315,902	208,868				2
3	Intermittent Peritoneal						3
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	412	272				6
7	CCPD	1,172	775				7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	1,553	1,027				10
11	CCPD	92,403	61,095				11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments	9,221	6,097				12
13	Method II Home Patient						13
14	EPO						14
15	ARANESP						15
16	Other						16
17	Total Statistical Basis	420,663	278,134			1,977,982	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	0.265203	0.772480			0.544724	18

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/30/2015 Run Time: 13:38 Version: 2015.03 (06/25/2015)
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COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

Check applicable box: Renal Dialysis Department Home Program Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments	Number of Program Treatments	Total Program Expenses (see instructions)	
		1	2	3	4	4.01	4.02	5	
1	Maintenance - Hemodialysis	9,969	2,294,488	230.16	7,077			1,628,842	1
2	Maintenance - Peritoneal Dialysis								2
3	Training - Hemodialysis								3
4	Training - Peritoneal Dialysis								4
5	Training - Continuous Ambulatory Peritoneal Dialysis	13	3,009	231.46	5			1,157	5
6	Training - Continuous Cycling Peritoneal Dialysis	37	8,542	230.86	25			5,772	6
7	Home Program - Hemodialysis								7
8	Home Program - Peritoneal Dialysis								8
		Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks		
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	104	11,293	108.59	54			5,864	9
10	Home Program - COntinuous Cycling Peritoneal Dialysis	1,593	671,153	421.31	1,593			671,147	10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)	10,019	2,988,485		7,107			2,312,782	11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	15,110							12

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COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

Check applicable box: Renal Dialysis Department Home Program Dialysis

		Total Program Payment	Total Program Payment	Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02)	
		6	6.01	6.02	7	7.01	7.02	
1	Maintenance - Hemodialysis	1,747,862			246.98			1
2	Maintenance - Peritoneal Dialysis							2
3	Training - Hemodialysis							3
4	Training - Peritoneal Dialysis							4
5	Training - Continuous Ambulatory Peritoneal Dialysis	1,399			279.80			5
6	Training - Continuous Cycling Peritoneal Dialysis	7,359			294.36			6
7	Home Program - Hemodialysis							7
8	Home Program - Peritoneal Dialysis							8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	5,524			102.30			9
10	Home Program - Continuous Cycling Peritoneal Dialysis	173,568			108.96			10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6)	1,935,712						11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))							12

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CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

WORKSHEET I-5

DESCRIPTION			
1	Total expenses related to care of program beneficiaries (see instructions)		2,312,782 1
		1	2
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	1,935,712	1,935,712 2
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)		2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)		2.02
2.03	Total payment due (see instructions)	1,935,712	1,935,712 2.03
2.04	Outlier payments	3,417	2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)		3
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)		3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)	147	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	147	3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)		4
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)		4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)	387,115	4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	387,115	4.03
5	Bad debts for deductibles and coinsurance, net of bad debt recoveries		5
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012		5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013		5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014		5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014		5.04
5.05	Total bad debts (sum of line 5 through line 5.04)		5.05
6	Allowable bad debts (see instructions)		6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		7
8	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)		8
9	Program payment (see instructions)		1,548,570 9
10	Unrecovered from Medicare (Part B) patients (see instructions)		10
11	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)		11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12	Total allowable expenses (see instructions)	2,988,485	12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)	2,988,485	13
14	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000	14

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 52-0100

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,114,914	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	100,243	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)	49.51	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)	0.0615	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1760	8
9	Sum of lines 7 and 8	0.2375	9
10	Allowable disproportionate share percentage (see instructions)	0.0493	10
11	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	54,965	11
12	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,270,122	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
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
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG						76.01
76.02	GI						76.02
76.03	NUCLEAR MED						76.03
76.04	PSYCH						76.04
76.05	ULTRASOUND						76.05
76.06	VASCULAR LAB						76.06
76.07	MEDICAL OUTPATIENT						76.07
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PROVIDER BASED PHYSICIAN CLINICS						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.0	PHYSIATRY CLINIC							194.0
1								1
194.0	JANESVILLE MED CTR							194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS							194.0
3								3
194.0	ASSISTED LIVING CENTERS							194.0
4								4
194.0	NORTHPOINTE FITNESS & SPA CENTER							194.0
5								5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202