

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

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

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 05/19/2017 Time: 11:01	
	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 01/01/2016 and ending 12/31/2016, 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		151,876	543,951	395	42,256	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						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		151,876	543,951	395	42,256	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: 1969 WEST HART ROAD	P.O. Box:				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 / 2016	To: 12 / 31 / 2016		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.	1,182	367	127	36	1,858		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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (see instructions)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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**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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		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-L, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	299,634			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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	Y	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.25				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2017	03 / 31 / 2017			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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0		171

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports					
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	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				
		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/18/2017	Y	04/18/2017
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 services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: AARON	Last name: WIERSEMA	Title: SR FINANCIAL ANALYST	41
42	Employer: BELOIT HEALTH SYSTEM INC			42
43	Phone number: 6083645102	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				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	91	33,306			7,427	900	14,997	1
2	HMO and other (see instructions)						1,684	2,388		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	33,306			7,427	900	14,997	7
8	Intensive Care Unit	31	12	4,392			1,180	50	2,103	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						232	1,146	13
14	Total (see instructions)		103	37,698			8,607	1,182	18,246	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					6,956	406	9,916	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							47	837	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

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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)					1,897	290	4,150	1
2	HMO and other (see instructions)					422	454		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)		1,301.00			1,897	290	4,150	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		18.00						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)		1,319.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	93,988,449	93,988,449	2,742,858.00	34.27	1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B		65,201	65,201	2,351.00	27.73	3
4	Physician-Part A - Administrative		721,547	721,547	4,164.00	173.28	4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B		23,619,298	23,619,298	119,429.00	197.77	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 and/or related organization personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)		4,663,618	4,663,618	201,444.00	23.15	10
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		523,502	523,502	6,500.00	80.54	11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative						13
14	Home office salaries & wage-related costs						14
14.01	Home office salaries						14.01
14.02	Related organization salaries						14.02
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)		32,434,105	32,434,105			17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		3,523,998	3,523,998			19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B		33,808	33,808			21
22	Physician Part A - Administrative		109,866	109,866			22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B		3,552,346	3,552,346			23
24	Wage-related costs (RHC/FQHC)						24
25	Interns & residents (in an approved program)						25
25.50	Home office wage-related						25.50
25.51	Related organization wage-related						25.51
25.52	Home office: Physician Part A - Administrative - wage-related						25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department						26
27	Administrative & General		11,854,716	11,854,716	493,177.00	24.04	27
28	Administrative & General under contract (see instructions)		397,314	397,314	1,838.00	216.17	28
29	Maintenance & Repairs						29
30	Operation of Plant		1,743,282	1,743,282	66,918.00	26.05	30
31	Laundry & Linen Service		56,178	56,178	5,033.00	11.16	31
32	Housekeeping		1,267,925	1,267,925	101,031.00	12.55	32
33	Housekeeping under contract (see instructions)						33
34	Dietary		882,711	882,711	56,375.00	15.66	34
35	Dietary under contract (see instructions)						35
36	Cafeteria		90,406	90,406	8,331.00	10.85	36
37	Maintenance of Personnel						37
38	Nursing Administration		1,354,904	1,354,904	46,380.00	29.21	38
39	Central Services and Supply		599,564	599,564	32,808.00	18.27	39
40	Pharmacy		1,782,673	1,782,673	44,012.00	40.50	40
41	Medical Records & Medical Records Library		2,409,832	2,409,832	118,198.00	20.39	41
42	Social Service		422,337	422,337	14,315.00	29.50	42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		70,701,264	70,701,264	2,622,916.00	26.96	1
2	Excluded area salaries (see instructions)		4,663,618	4,663,618	201,444.00	23.15	2
3	Subtotal salaries (line 1 minus line 2)		66,037,646	66,037,646	2,421,472.00	27.27	3
4	Subtotal other wages & related costs (see instructions)		523,502	523,502	6,500.00	80.54	4

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III**

5	Subtotal wage-related costs (see instructions)		32,543,971		32,543,971		49.28%	5
6	Total (sum of lines 3 through 5)		99,105,119		99,105,119	2,427,972.00	40.82	6
7	Total overhead cost (see instructions)		22,861,842		22,861,842	988,416.00	23.13	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	3,665,929	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	26,249,292	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	565,913	10
11	Life Insurance (If employee is owner or beneficiary)	74,436	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	316,597	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	531,491	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	5,808,591	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	93,130	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	825,778	23
24	Total Wage Related cost (Sum of lines 1-23)	39,654,124	24

Part B - Other Than Core Related Cost

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

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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 1	Benefit Cost 2	
	0			
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL-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		1,903	111	699	2,713	1
2	Unduplicated Census Count (see instructions)		354.00				2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)				
		Staff	Contract	Total		
		1	2	3		
3	Administrator and Assistant Administrator(s)				3	
4	Director(s) and Assistant Director(s)				4	
5	Other Administrative Personnel		3.00		3.00	5
6	Direct Nursing Service		9.00		9.00	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		1.00		1.00	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.	4	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	27500	20
20.01		31540	20.01
20.02		40420	20.02
20.03		99952	20.03

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	2,683	455	103	44	3,285	21
22	Skilled Nursing Visit Charges	1,034,064	174,720	40,117	16,896	1,265,797	22
23	Physical Therapy Visits	1,732	15	36	41	1,824	23
24	Physical Therapy Visit Charges	726,576	6,300	15,120	17,220	765,216	24
25	Occupational Therapy Visits	566	17	8	6	597	25
26	Occupational Therapy Visit Charges	237,352	7,140	3,360	2,520	250,372	26
27	Speech Pathology Visits	21		2		23	27
28	Speech Pathology Visit Charges	8,820		840		9,660	28
29	Medical Social Service Visits	4				4	29
30	Medical Social Service Visit Charges	2,192				2,192	30
31	Home Health Aide Visits	818	102	7		927	31
32	Home Health Aide Visit Charges	148,987	18,666	1,281		168,934	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,824	589	156	91	6,660	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,157,991	206,826	60,718	36,636	2,462,171	35
36	Total Number of Episodes (standard/non-outlier)	388		61	11	460	36
37	Total Number of Outlier Episodes		13			13	37
38	Total Non-Routine Medical Supply Charges	386,770	109,248	10,112	1,252	507,382	38

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	63					22	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

11	Number of patients on transplant list		8	11
12	Number of patients transplanted during the cost reporting period		2	12

EPOETIN

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

ARANESP

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

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

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

LOW VOLUME		CCN	Treatments		
		1	2		
23	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part 1, line 18 and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)				23

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)	0.236664	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	21,484,390	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	123,327,844	6
7	Medicaid cost (line 1 times line 6)	29,187,261	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.	7,702,871	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)	7,702,871	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,486,652		1,486,652	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	351,837		351,837	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	351,837		351,837	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)	13,034,255	26
27	Medicare bad debts for the entire hospital complex (see instructions)	638,808	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	12,395,447	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,933,556	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,285,393	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,988,264	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		6,870,561	6,870,561	3,736,425	10,606,986	-997,693	9,609,293	1
2	00200	Cap Rel Costs-Mvble Equip		3,448,280	3,448,280	1,190,048	4,638,328		4,638,328	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		39,125,958	39,125,958		39,125,958	-12,051,510	27,074,448	4
5	00500	Administrative & General	11,854,716	18,831,912	30,686,628	-1,194,864	29,491,764	-7,276,052	22,215,712	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,743,282	5,291,128	7,034,410	-20,451	7,013,959	-763,243	6,250,716	7
8	00800	Laundry & Linen Service	56,178	567,263	623,441		623,441	-24,525	598,916	8
9	00900	Housekeeping	1,267,925	349,643	1,617,568		1,617,568	-274,028	1,343,540	9
10	01000	Dietary	882,711	387,694	1,270,405		1,270,405	-228	1,270,177	10
11	01100	Cafeteria	90,406	550,929	641,335		641,335	-522,918	118,417	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,354,904	59,038	1,413,942		1,413,942	-585,248	828,694	13
14	01400	Central Services & Supply	599,564	555,270	1,154,834	-186,609	968,225		968,225	14
15	01500	Pharmacy	1,782,673	157,721	1,940,394	-1,645	1,938,749	429	1,939,178	15
16	01600	Medical Records & Library	2,409,832	997,232	3,407,064		3,407,064	-712,928	2,694,136	16
17	01700	Social Service	422,337	5,459	427,796		427,796		427,796	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	7,083,452	267,234	7,350,686	-21,933	7,328,753	-65	7,328,688	30
31	03100	Intensive Care Unit	1,842,668	230,268	2,072,936		2,072,936		2,072,936	31
43	04300	Nursery	180,677		180,677		180,677		180,677	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,871,599	868,452	2,740,051	-4,630	2,735,421		2,735,421	50
51	05100	Recovery Room	345,344	6,725	352,069		352,069		352,069	51
52	05200	Delivery Room & Labor Room	446,377		446,377		446,377		446,377	52
53	05300	Anesthesiology	65,201	213,269	278,470	-3,000	275,470	-65,201	210,269	53
54	05400	Radiology-Diagnostic	1,477,163	617,229	2,094,392	-2,178	2,092,214	-340,495	1,751,719	54
55	05500	Radiology-Therapeutic	386,802	455,012	841,814		841,814		841,814	55
57	05700	CT Scan	854,843	523,115	1,377,958		1,377,958		1,377,958	57
58	05800	MRI	346,521	325,760	672,281		672,281	-6,300	665,981	58
59	05900	Cardiac Catheterization	1,417,439	602,124	2,019,563	-18,400	2,001,163		2,001,163	59
60	06000	Laboratory	2,974,726	4,734,210	7,708,936		7,708,936	-178	7,708,758	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	782,591	272,908	1,055,499	-6,875	1,048,624		1,048,624	65
66	06600	Physical Therapy	2,513,722	196,647	2,710,369	-14,301	2,696,068	-1,161,335	1,534,733	66
67	06700	Occupational Therapy	237,629	56,067	293,696		293,696	-120,239	173,457	67
68	06800	Speech Pathology	145,658	6,854	152,512		152,512		152,512	68
69	06900	Electrocardiology	249,103	43,742	292,845		292,845	-42,094	250,751	69
71	07100	Medical Supplies Charged to Patients		11,191,050	11,191,050		11,191,050	-971,962	10,219,088	71
73	07300	Drugs Charged to Patients		16,368,437	16,368,437		16,368,437	-3,480,032	12,888,405	73
74	07400	Renal Dialysis	1,195,700	2,024,428	3,220,128		3,220,128		3,220,128	74
75	07500	ASC (Non-Distinct Part)	448,706	12,514	461,220		461,220		461,220	75
76	03950	OTHER ANCILLARY								76
76.01	03280	SLEEP/EEG	224,075	22,525	246,600	-2,046	244,554		244,554	76.01
76.02	03340	GI	690,538	250,442	940,980		940,980		940,980	76.02
76.03	03450	NUCLEAR MED	285,497	238,029	523,526		523,526		523,526	76.03
76.04	03550	PSYCH	1,631,804	640,215	2,272,019	-3,060	2,268,959	-584,451	1,684,508	76.04
76.05	03630	ULTRASOUND	441,839	103,891	545,730		545,730	-93,943	451,787	76.05
76.06	03650	VASCULAR LAB	491,615	44,958	536,573		536,573	-864	535,709	76.06
76.07	03951	MEDICAL OUTPATIENT	342,351	10,722	353,073		353,073		353,073	76.07
76.97	07697	CARDIAC REHABILITATION	193,014	8,014	201,028		201,028	-11	201,017	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY		71,600	71,600		71,600		71,600	76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	33,675,799	3,544,111	37,219,910		37,219,910	-37,219,910		90
91	09100	Emergency	4,017,850	815,254	4,833,104		4,833,104	-350,051	4,483,053	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,227,073	218,487	1,445,560		1,445,560	-1,354	1,444,206	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		3,421,697	3,421,697	-3,421,697				113
118		SUBTOTALS (sum of lines 1-117)	90,551,904	125,604,078	216,155,982	24,784	216,180,766	-67,646,429	148,534,337	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	44,969	57,743	102,712		102,712		102,712	190
194	07950	PATHOLOGY	19,723	6,542	26,265		26,265		26,265	194
194.0 1	07951	PHYSIATRY CLINIC	252,824	1,331	254,155		254,155		254,155	194.0 1
194.0 2	07952	JANESVILLE MED CTR	160,504	66,831	227,335	-17,340	209,995		209,995	194.0 2
194.0 3	07953	OCCUPATIONAL HEALTH & WELLNESS	1,164,073	211,433	1,375,506		1,375,506		1,375,506	194.0 3
194.0 4	07954	ASSISTED LIVING CENTERS	1,528,275	794,431	2,322,706	-7,444	2,315,262		2,315,262	194.0 4
194.0 5	07955	NORTHPOINTE FITNESS AND SPA CENTER	266,177	2,244,831	2,511,008		2,511,008		2,511,008	194.0 5
200		TOTAL (sum of lines 118-199)	93,988,449	128,987,220	222,975,669		222,975,669	-67,646,429	155,329,240	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		3,265,646	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Mvble Equip	2		156,051	2
500	Total reclassifications					3,421,697	500
	Code Letter - A						
1	RENTS AND LEASES	B	Cap Rel Costs-Bldg & Fixt	1		470,779	1
2	RENTS AND LEASES	B	Cap Rel Costs-Mvble Equip	2		1,033,997	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
500	Total reclassifications					1,504,776	500
	Code Letter - B						
	GRAND TOTAL (Increases)					4,926,473	

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		3,265,646	11	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Interest Expense	113		156,051	11	2
500	Total reclassifications					3,421,697		500
	Code letter - A							
1	RENTS AND LEASES	B	Administrative & General	5		1,194,864	10	1
2	RENTS AND LEASES	B	Operation of Plant	7		20,451	10	2
3			Central Services & Supply	14		186,609	10	3
4			Pharmacy	15		1,645	10	4
5			Adults & Pediatrics	30		21,933	10	5
6			Operating Room	50		4,630	10	6
7			Anesthesiology	53		3,000	10	7
8			Radiology-Diagnostic	54		2,178	10	8
9			Cardiac Catheterization	59		18,400	10	9
10			Respiratory Therapy	65		6,875	10	10
11			Physical Therapy	66		14,301	10	11
12			SLEEP/EEG	76.01		2,046	10	12
13			PSYCH	76.04		3,060	10	13
14			JANESVILLE MED CTR	194.02		17,340	10	14
15			ASSISTED LIVING CENTERS	194.04		7,444	10	15
500	Total reclassifications					1,504,776		500
	Code letter - B							
	GRAND TOTAL (Decreases)					4,926,473		

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	6,300,943					6,300,943	2,285,465	2
3	Buildings and Fixtures	119,498,729	2,151,139		2,151,139		121,649,868	20,491,805	3
4	Building Improvements								4
5	Fixed Equipment	37,781,084	3,450,885		3,450,885		41,231,969	12,517,785	5
6	Movable Equipment	61,065,473	2,865,696		2,865,696		63,931,169	41,338,017	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	232,747,106	8,467,720		8,467,720		241,214,826	76,633,072	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	232,747,106	8,467,720		8,467,720		241,214,826	76,633,072	10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	6,870,561						6,870,561	1	
2	Cap Rel Costs-Mvble Equip	3,448,280						3,448,280	2	
3	Total (sum of lines 1-2)	10,318,841						10,318,841	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	177,283,657		177,283,657	0.734962					1
2	Cap Rel Costs-Mvble Equip	63,931,169		63,931,169	0.265038					2
3	Total (sum of lines 1-2)	241,214,826		241,214,826	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	5,872,868	470,779	3,265,646				9,609,293	1	
2	Cap Rel Costs-Mvble Equip	3,448,280	1,033,997	156,051				4,638,328	2	
3	Total (sum of lines 1-2)	9,321,148	1,504,776	3,421,697				14,247,621	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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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)	A	-65,448	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-25,002,481			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 anesthesiologist			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	-26,552	Employee Benefits Department	4	33
34	CRNA OFFSET	A	-65,201	Anesthesiology	53	34
35	PATIENT PORTION OF OPERATORS TIME	A	-1,548	Employee Benefits Department	4	35
36	PATIENT PORTION OF OPERATORS TIME	A	-3,802	Administrative & General	5	36
37	ADVERTISING OFFSET	A	-777,469	Administrative & General	5	37
38	ADVERTISING OFFSET	A	-50	Operation of Plant	7	38
39	ADVERTISING OFFSET	A	-69	Housekeeping	9	39
40	ADVERTISING OFFSET	A	-85	Dietary	10	40
41	ADVERTISING OFFSET	A	-49	Nursing Administration	13	41
42	ADVERTISING OFFSET	A	-40	Adults & Pediatrics	30	42
43	ADVERTISING OFFSET	A	-9,827	Physical Therapy	66	43
44	ADVERTISING OFFSET	A	-51	Emergency	91	44
45	MISC REV OFFSET	B	-563,371	Administrative & General	5	45
46	MISC REV OFFSET	B	-8,074	Operation of Plant	7	46
47	MISC REV OFFSET	B	-50	Laundry & Linen Service	8	47
48	MISC REV OFFSET	B	-7,285	Housekeeping	9	48
49	MISC REV OFFSET	B	-143	Dietary	10	49
49.01	MISC REV OFFSET	B	-522,918	Cafeteria	11	49.01
49.02	MISC REV OFFSET	B	429	Pharmacy	15	49.02
49.03	MISC REV OFFSET	B	-7,020	Medical Records & Library	16	49.03
49.04	MISC REV OFFSET	B	-25	Adults & Pediatrics	30	49.04
49.05	MISC REV OFFSET	B	-5	Radiology-Diagnostic	54	49.05
49.06	MISC REV OFFSET	B	-6,300	MRI	58	49.06
49.07	MISC REV OFFSET	B	-1,143	Physical Therapy	66	49.07
49.08	MISC REV OFFSET	B	-111,317	PSYCH	76.04	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	MISC REV OFFSET	B	-864	VASCULAR LAB	76.06	49.09
49.10	MISC REV OFFSET	B	-11	CARDIAC REHABILITATION	76.97	49.10
49.11	MISC REV OFFSET	B	-1,354	Home Health Agency	101	49.11
49.12	REMOVE PHYSICIAN CLINIC COSTS	A	-997,693	Cap Rel Costs-Bldg & Fixt	1	9 49.12
49.13	REMOVE PHYSICIAN CLINIC COSTS	A	-12,023,410	Employee Benefits Department	4	49.13
49.14	REMOVE PHYSICIAN CLINIC COSTS	A	-5,931,410	Administrative & General	5	49.14
49.15	REMOVE PHYSICIAN CLINIC COSTS	A	-689,671	Operation of Plant	7	49.15
49.16	REMOVE PHYSICIAN CLINIC COSTS	A	-24,475	Laundry & Linen Service	8	49.16
49.17	REMOVE PHYSICIAN CLINIC COSTS	A	-266,674	Housekeeping	9	49.17
49.18	REMOVE PHYSICIAN CLINIC COSTS	A	-585,199	Nursing Administration	13	49.18
49.19	REMOVE PHYSICIAN CLINIC COSTS	A	-705,908	Medical Records & Library	16	49.19
49.20	REMOVE PHYSICIAN CLINIC COSTS	A	-340,490	Radiology-Diagnostic	54	49.20
49.21	REMOVE PHYSICIAN CLINIC COSTS	A	-178	Laboratory	60	49.21
49.22	REMOVE PHYSICIAN CLINIC COSTS	A	-1,150,365	Physical Therapy	66	49.22
49.23	REMOVE PHYSICIAN CLINIC COSTS	A	-120,239	Occupational Therapy	67	49.23
49.24	REMOVE PHYSICIAN CLINIC COSTS	A	-42,094	Electrocardiology	69	49.24
49.25	REMOVE PHYSICIAN CLINIC COSTS	A	-971,962	Medical Supplies Charged to Patients	71	49.25
49.26	REMOVE PHYSICIAN CLINIC COSTS	A	-3,480,032	Drugs Charged to Patients	73	49.26
49.27	REMOVE PHYSICIAN CLINIC COSTS	A	-93,943	ULTRASOUND	76.05	49.27
49.28	REMOVE PHYSICIAN CLINIC COSTS	A	-13,040,563	Clinic	90	49.28
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-67,646,429			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1						1	
2						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	Related Organization(s) and/or Home Office			
			Percentage of Ownership	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	Clinic FAMILY PRACTICE	2,503,110	2,376,532	126,578	179,000	1,064	91,565	4,578	1
2	90	Clinic INT MEDICINE	1,858,886	1,705,477	153,409	197,500	1,406	133,502	6,675	2
3	90	Clinic SURGERY	4,339,822	4,245,163	94,659	246,400	444	52,597	2,630	3
4	90	Clinic PEDIATRICS	1,031,028	1,024,028	7,000	169,700	47	3,835	192	4
5	90	Clinic OB/GYN	1,936,681	1,926,725	9,956	237,100	50	5,699	285	5
6	90	Clinic ALL OTHERS	12,671,318	12,341,373	329,945	211,500	1,153	117,240	5,862	6
7	91	Emergency ER PHYSICIANS	350,000	350,000		211,500				7
8	76.04	PSYCH PSYCHIATRY PHYS	473,134	473,134		181,300				8
9	90	Clinic ORTHO SURGERY	40,575	40,575		246,400				9
10	90	Clinic CARDIAC SURGERY	219,000	219,000		246,400				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	25,423,554	24,702,007	721,547		4,164	404,438	20,222	200

KPMG LLP Compu-Max 2552-10

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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	Clinic FAMILY PRACTICE	30,107	1,522	26,151	1,322	94,409	32,169	2,408,701	1
2	90	Clinic INT MEDICINE	33,167	2,737	20,081	1,657	137,896	15,513	1,720,990	2
3	90	Clinic SURGERY	41,688	909	74,322	1,621	55,127	39,532	4,284,695	3
4	90	Clinic PEDIATRICS	9,477	64	14,043	95	3,994	3,006	1,027,034	4
5	90	Clinic OB/GYN	14,561	75	53,564	275	6,049	3,907	1,930,632	5
6	90	Clinic ALL OTHERS	132,685	3,455	111,473	2,903	123,598	206,347	12,547,720	6
7	91	Emergency ER PHYSICIANS							350,000	7
8	76.04	PSYCH PSYCHIATRY PHYS							473,134	8
9	90	Clinic ORTHO SURGERY							40,575	9
10	90	Clinic CARDIAC SURGERY							219,000	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	261,685	8,762	299,634	7,873	421,073	300,474	25,002,481	200

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	9,609,293	9,609,293					1
2	Cap Rel Costs-Mvble Equip	4,638,328		4,638,328				2
4	Employee Benefits Department	27,074,448			27,074,448			4
5	Administrative & General	22,215,712	2,747,283	1,346,271	5,321,585	31,630,851	31,630,851	5
6	Maintenance & Repairs							6
7	Operation of Plant	6,250,716	536,153	89,273	782,563	7,658,705	1,958,400	7
8	Laundry & Linen Service	598,916	25,526		25,218	649,660	166,124	8
9	Housekeeping	1,343,540	7,474	2,994	569,174	1,923,182	491,775	9
10	Dietary	1,270,177	76,577	10,888	396,251	1,753,893	448,486	10
11	Cafeteria	118,417	71,025	2,315	40,583	232,340	59,411	11
12	Maintenance of Personnel							12
13	Nursing Administration	828,694	29,698	100,990	608,219	1,567,601	400,850	13
14	Central Services & Supply	968,225	131,291	266,049	269,145	1,634,710	418,010	14
15	Pharmacy	1,939,178	43,561	185,940	800,245	2,968,924	759,181	15
16	Medical Records & Library	2,694,136	167,510	112	1,081,778	3,943,536	1,008,398	16
17	Social Service	427,796	8,131		189,588	625,515	159,950	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	7,328,688	691,261	116,738	3,179,776	11,316,463	2,893,721	30
31	Intensive Care Unit	2,072,936	59,051	15,897	827,177	2,975,061	760,750	31
43	Nursery	180,677			81,106	261,783	66,940	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,735,421	192,231	236,938	840,165	4,004,755	1,024,052	50
51	Recovery Room	352,069	20,992		155,026	528,087	135,037	51
52	Delivery Room & Labor Room	446,377			200,380	646,757	165,382	52
53	Anesthesiology	210,269	7,966	24,576	29,269	272,080	69,573	53
54	Radiology-Diagnostic	1,751,719	226,955	238,376	663,101	2,880,151	736,481	54
55	Radiology-Therapeutic	841,814	111,465	77,816	173,636	1,204,731	308,061	55
57	CT Scan	1,377,958	21,813	133,319	383,741	1,916,831	490,151	57
58	MRI	665,981	15,572	92,719	155,554	929,826	237,765	58
59	Cardiac Catheterization	2,001,163	66,081	295,214	636,291	2,998,749	766,807	59
60	Laboratory	7,708,758	245,039	179,235	1,335,360	9,468,392	2,421,153	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,048,624	40,900	47,973	351,307	1,488,804	380,701	65
66	Physical Therapy	1,534,733	259,313	45,958	1,128,415	2,968,419	759,051	66
67	Occupational Therapy	173,457	13,075		106,672	293,204	74,975	67
68	Speech Pathology	152,512	7,474	376	65,386	225,748	57,726	68
69	Electrocardiology	250,751	8,049	11,937	111,823	382,560	97,824	69
71	Medical Supplies Charged to Patients	10,219,088				10,219,088	2,613,113	71
73	Drugs Charged to Patients	12,888,405				12,888,405	3,295,738	73
74	Renal Dialysis	3,220,128	115,917	71,323	536,752	3,944,120	1,008,547	74
75	ASC (Non-Distinct Part)	461,220	129,780	14,820	201,425	807,245	206,420	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	244,554	11,104	12,433	100,588	368,679	94,275	76.01
76.02	GI	940,980	50,706	134,789	309,984	1,436,459	367,315	76.02
76.03	NUCLEAR MED	523,526	12,829	7,744	128,160	672,259	171,903	76.03
76.04	PSYCH	1,684,508	103,285	2,702	732,520	2,523,015	645,158	76.04
76.05	ULTRASOUND	451,787	25,575	103,241	198,342	778,945	199,183	76.05
76.06	VASCULAR LAB	535,709	32,786	124,097	220,687	913,279	233,534	76.06
76.07	MEDICAL OUTPATIENT	353,073	16,426	2,620	153,682	525,801	134,452	76.07
76.97	CARDIAC REHABILITATION	201,017	27,645	13,289	86,644	328,595	84,025	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	71,600				71,600	18,309	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	4,483,053	432,244	534,640	1,803,621	7,253,558	1,854,800	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,444,206	55,125		550,836	2,050,167	524,246	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	148,534,337	6,844,888	4,543,602	25,531,775	144,132,533	28,767,753	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	102,712	19,251	7,694	20,187	149,844	38,316	190
194	PATHOLOGY	26,265	8,525	5,376	8,854	49,020	12,535	194
194.0	PHYSIATRY CLINIC	254,155	11,071		113,493	378,719	96,842	194.0
1								1
194.0	JANESVILLE MED CTR	209,995	82,572	5,010	72,051	369,628	94,517	194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS	1,375,506	143,348	3,115	522,555	2,044,524	522,803	194.0
3								3
194.0	ASSISTED LIVING CENTERS	2,315,262	1,563,452	26,654	686,046	4,591,414	1,174,066	194.0
4								4
194.0	NORTHPOINTE FITNESS AND SPA CENTER	2,511,008	936,186	46,877	119,487	3,613,558	924,019	194.0
5								5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	155,329,240	9,609,293	4,638,328	27,074,448	155,329,240	31,630,851	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	
	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	9,617,105						7
8	Laundry & Linen Service	38,806	854,590					8
9	Housekeeping	11,362		2,426,319				9
10	Dietary	116,419		29,526	2,348,324			10
11	Cafeteria	107,978		27,385		427,114		11
12	Maintenance of Personnel							12
13	Nursing Administration	45,149		11,450		14,434	2,039,484	13
14	Central Services & Supply	199,600		50,622		10,497		14
15	Pharmacy	66,225		16,796		13,778		15
16	Medical Records & Library	254,663		64,586		37,397		16
17	Social Service	12,361		3,135		4,593		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	1,050,915	379,677	266,528	2,059,521	83,982	781,599	30
31	Intensive Care Unit	89,774	47,780	22,768	288,803	18,370	170,975	31
43	Nursery					1,968	18,319	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	292,245	124,741	74,118		19,027	177,081	50
51	Recovery Room	31,914		8,094		2,624	24,425	51
52	Delivery Room & Labor Room					4,593	42,744	52
53	Anesthesiology	12,111		3,072		656	6,106	53
54	Radiology-Diagnostic	345,036	70,868	87,506		17,058		54
55	Radiology-Therapeutic	169,459		42,977		3,280		55
57	CT Scan	33,163		8,411		7,217		57
58	MRI	23,673		6,004		2,624		58
59	Cardiac Catheterization	100,462		25,479		11,810		59
60	Laboratory	372,530		94,479		39,365		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	62,180		15,770		7,873		65
66	Physical Therapy	394,230	19,721	99,983		22,963		66
67	Occupational Therapy	19,878		5,041		1,968		67
68	Speech Pathology	11,362		2,882		1,312		68
69	Electrocardiology	12,236		3,103		4,593		69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	176,226	31,586	44,694		14,434	134,337	74
75	ASC (Non-Distinct Part)	197,303	26,455	50,039		3,937	36,637	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	16,881		4,281		2,624	24,425	76.01
76.02	GI	77,088		19,551		8,529	79,381	76.02
76.03	NUCLEAR MED	19,503		4,946		1,968		76.03
76.04	PSYCH	157,023		39,823		13,778		76.04
76.05	ULTRASOUND	38,881		9,861		3,280		76.05
76.06	VASCULAR LAB	49,844	10,261	12,641		3,937	36,637	76.06
76.07	MEDICAL OUTPATIENT	24,972		6,333		3,280	30,531	76.07
76.97	CARDIAC REHABILITATION	42,028		10,659		1,968	18,319	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	657,134	143,501	166,659		37,397	348,056	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	83,805		21,254			109,912	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	5,414,419	854,590	1,360,456	2,348,324	427,114	2,039,484	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	29,267		7,423				190

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	12,960		3,287				194
194.0 1	PHYSIATRY CLINIC	16,831		4,269				194.0 1
194.0 2	JANESVILLE MED CTR	125,533		31,837				194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	217,929		55,270				194.0 3
194.0 4	ASSISTED LIVING CENTERS	2,376,896		602,814				194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER	1,423,270		360,963				194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,617,105	854,590	2,426,319	2,348,324	427,114	2,039,484	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	2,313,439						14
15	Pharmacy	10,199	3,835,103					15
16	Medical Records & Library			5,308,580				16
17	Social Service				805,554			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	107,556	349	200,752	805,554	19,946,617		30
31	Intensive Care Unit	26,909	53	86,433		4,487,676		31
43	Nursery			17,298		366,308		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	392,721	24,369	304,416		6,437,525		50
51	Recovery Room	4,323	87	20,437		755,028		51
52	Delivery Room & Labor Room			43,144		902,620		52
53	Anesthesiology	32,785	15,887	39,553		451,823		53
54	Radiology-Diagnostic	16,228	1,760	180,774		4,335,862		54
55	Radiology-Therapeutic	5,325		108,353		1,842,186		55
57	CT Scan	8,246	953	384,423		2,849,395		57
58	MRI	785	451	195,347		1,396,475		58
59	Cardiac Catheterization	462,478	15,513	131,108		4,512,406		59
60	Laboratory	3,739	16	862,294		13,261,968		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10,738		45,880		2,011,946		65
66	Physical Therapy	44,501		134,043		4,442,911		66
67	Occupational Therapy	67		24,163		419,296		67
68	Speech Pathology	3,255	6	5,113		307,404		68
69	Electrocardiology	4,194		135,843		640,353		69
71	Medical Supplies Charged to Patients	769,527		854,288		14,456,016		71
73	Drugs Charged to Patients		3,392,545	564,074		20,140,762		73
74	Renal Dialysis	167,200	244,492	138,304		5,903,940		74
75	ASC (Non-Distinct Part)	17,897	93	22,586		1,368,612		75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	34		18,101		529,300		76.01
76.02	GI	93,346	5,542	140,175		2,227,386		76.02
76.03	NUCLEAR MED	816	114,027	82,764		1,068,186		76.03
76.04	PSYCH	185		34,543		3,413,525		76.04
76.05	ULTRASOUND	5,711	191	92,863		1,128,915		76.05
76.06	VASCULAR LAB	682		70,480		1,331,295		76.06
76.07	MEDICAL OUTPATIENT	14,744	1,495	7,531		749,139		76.07
76.97	CARDIAC REHABILITATION	311		9,769		495,674		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY			390		90,299		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	99,480	1,100	336,709		10,898,394		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	8,511	865	16,629		2,815,389		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	2,312,493	3,819,794	5,308,580	805,554	135,984,631		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					224,850		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	104				77,906		194
194.0	PHYSIATRY CLINIC	1				496,662		194.0
1								1
194.0	JANESVILLE MED CTR	26	837			622,378		194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS	339	14,309			2,855,174		194.0
3								3
194.0	ASSISTED LIVING CENTERS	433	116			8,745,739		194.0
4								4
194.0	NORTHPOINTE FITNESS AND SPA CENTER	43	47			6,321,900		194.0
5								5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,313,439	3,835,103	5,308,580	805,554	155,329,240		202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	19,946,617					30
31	Intensive Care Unit	4,487,676					31
43	Nursery	366,308					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,437,525					50
51	Recovery Room	755,028					51
52	Delivery Room & Labor Room	902,620					52
53	Anesthesiology	451,823					53
54	Radiology-Diagnostic	4,335,862					54
55	Radiology-Therapeutic	1,842,186					55
57	CT Scan	2,849,395					57
58	MRI	1,396,475					58
59	Cardiac Catheterization	4,512,406					59
60	Laboratory	13,261,968					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,011,946					65
66	Physical Therapy	4,442,911					66
67	Occupational Therapy	419,296					67
68	Speech Pathology	307,404					68
69	Electrocardiology	640,353					69
71	Medical Supplies Charged to Patients	14,456,016					71
73	Drugs Charged to Patients	20,140,762					73
74	Renal Dialysis	5,903,940					74
75	ASC (Non-Distinct Part)	1,368,612					75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	529,300					76.01
76.02	GI	2,227,386					76.02
76.03	NUCLEAR MED	1,068,186					76.03
76.04	PSYCH	3,413,525					76.04
76.05	ULTRASOUND	1,128,915					76.05
76.06	VASCULAR LAB	1,331,295					76.06
76.07	MEDICAL OUTPATIENT	749,139					76.07
76.97	CARDIAC REHABILITATION	495,674					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	90,299					76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	10,898,394					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,815,389					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	135,984,631					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	224,850					190

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
194	PATHOLOGY	77,906					194
194.0 1	PHYSIATRY CLINIC	496,662					194.0 1
194.0 2	JANESVILLE MED CTR	622,378					194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	2,855,174					194.0 3
194.0 4	ASSISTED LIVING CENTERS	8,745,739					194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER	6,321,900					194.0 5
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	155,329,240					202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		2,747,283	1,346,271	4,093,554	4,093,554		5
6	Maintenance & Repairs							6
7	Operation of Plant		536,153	89,273	625,426	253,450	878,876	7
8	Laundry & Linen Service		25,526		25,526	21,499	3,546	8
9	Housekeeping		7,474	2,994	10,468	63,644	1,038	9
10	Dietary		76,577	10,888	87,465	58,042	10,639	10
11	Cafeteria		71,025	2,315	73,340	7,689	9,868	11
12	Maintenance of Personnel							12
13	Nursing Administration		29,698	100,990	130,688	51,877	4,126	13
14	Central Services & Supply		131,291	266,049	397,340	54,097	18,241	14
15	Pharmacy		43,561	185,940	229,501	98,251	6,052	15
16	Medical Records & Library		167,510	112	167,622	130,503	23,273	16
17	Social Service		8,131		8,131	20,700	1,130	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		691,261	116,738	807,999	374,496	96,040	30
31	Intensive Care Unit		59,051	15,897	74,948	98,454	8,204	31
43	Nursery					8,663		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		192,231	236,938	429,169	132,529	26,707	50
51	Recovery Room		20,992		20,992	17,476	2,917	51
52	Delivery Room & Labor Room					21,403		52
53	Anesthesiology		7,966	24,576	32,542	9,004	1,107	53
54	Radiology-Diagnostic		226,955	238,376	465,331	95,313	31,532	54
55	Radiology-Therapeutic		111,465	77,816	189,281	39,868	15,486	55
57	CT Scan		21,813	133,319	155,132	63,434	3,031	57
58	MRI		15,572	92,719	108,291	30,771	2,163	58
59	Cardiac Catheterization		66,081	295,214	361,295	99,238	9,181	59
60	Laboratory		245,039	179,235	424,274	313,337	34,044	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		40,900	47,973	88,873	49,269	5,682	65
66	Physical Therapy		259,313	45,958	305,271	98,234	36,027	66
67	Occupational Therapy		13,075		13,075	9,703	1,817	67
68	Speech Pathology		7,474	376	7,850	7,471	1,038	68
69	Electrocardiology		8,049	11,937	19,986	12,660	1,118	69
71	Medical Supplies Charged to Patients					338,180		71
73	Drugs Charged to Patients					426,519		73
74	Renal Dialysis		115,917	71,323	187,240	130,523	16,105	74
75	ASC (Non-Distinct Part)		129,780	14,820	144,600	26,714	18,031	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		11,104	12,433	23,537	12,201	1,543	76.01
76.02	GI		50,706	134,789	185,495	47,537	7,045	76.02
76.03	NUCLEAR MED		12,829	7,744	20,573	22,247	1,782	76.03
76.04	PSYCH		103,285	2,702	105,987	83,494	14,350	76.04
76.05	ULTRASOUND		25,575	103,241	128,816	25,778	3,553	76.05
76.06	VASCULAR LAB		32,786	124,097	156,883	30,223	4,555	76.06
76.07	MEDICAL OUTPATIENT		16,426	2,620	19,046	17,400	2,282	76.07
76.97	CARDIAC REHABILITATION		27,645	13,289	40,934	10,874	3,841	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					2,369		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		432,244	534,640	966,884	240,042	60,053	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		55,125		55,125	67,846	7,659	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		6,844,888	4,543,602	11,388,490	3,723,022	494,806	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		19,251	7,694	26,945	4,959	2,675	190

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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	
194	PATHOLOGY		8,525	5,376	13,901	1,622	1,184	194
194.0	PHYSIATRY CLINIC		11,071		11,071	12,533	1,538	194.0
1								1
194.0	JANESVILLE MED CTR		82,572	5,010	87,582	12,232	11,472	194.0
2								2
194.0	OCCUPATIONAL HEALTH & WELLNESS		143,348	3,115	146,463	67,659	19,916	194.0
3								3
194.0	ASSISTED LIVING CENTERS		1,563,452	26,654	1,590,106	151,944	217,217	194.0
4								4
194.0	NORTHPOINTE FITNESS AND SPA CENTER		936,186	46,877	983,063	119,583	130,068	194.0
5								5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		9,609,293	4,638,328	14,247,621	4,093,554	878,876	202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	50,571						8
9	Housekeeping		75,150					9
10	Dietary		914	157,060				10
11	Cafeteria		848		91,745			11
12	Maintenance of Personnel							12
13	Nursing Administration		355		3,100	190,146		13
14	Central Services & Supply		1,568		2,255		473,501	14
15	Pharmacy		520		2,960		2,087	15
16	Medical Records & Library		2,000		8,033			16
17	Social Service		97		987			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	22,467	8,255	137,744	18,033	72,871	22,014	30
31	Intensive Care Unit	2,827	705	19,316	3,946	15,940	5,508	31
43	Nursery				423	1,708		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,382	2,296		4,087	16,510	80,379	50
51	Recovery Room		251		564	2,277	885	51
52	Delivery Room & Labor Room				987	3,985		52
53	Anesthesiology		95		141	569	6,710	53
54	Radiology-Diagnostic	4,194	2,710		3,664		3,321	54
55	Radiology-Therapeutic		1,331		705		1,090	55
57	CT Scan		260		1,550		1,688	57
58	MRI		186		564		161	58
59	Cardiac Catheterization		789		2,537		94,657	59
60	Laboratory		2,926		8,456		765	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		488		1,691		2,198	65
66	Physical Therapy	1,167	3,097		4,933		9,108	66
67	Occupational Therapy		156		423		14	67
68	Speech Pathology		89		282		666	68
69	Electrocardiology		96		987		858	69
71	Medical Supplies Charged to Patients						157,504	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,869	1,384		3,100	12,525	34,221	74
75	ASC (Non-Distinct Part)	1,566	1,550		846	3,416	3,663	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		133		564	2,277	7	76.01
76.02	GI		606		1,832	7,401	19,105	76.02
76.03	NUCLEAR MED		153		423		167	76.03
76.04	PSYCH		1,233		2,960		38	76.04
76.05	ULTRASOUND		305		705		1,169	76.05
76.06	VASCULAR LAB	607	392		846	3,416	140	76.06
76.07	MEDICAL OUTPATIENT		196		705	2,846	3,018	76.07
76.97	CARDIAC REHABILITATION		330		423	1,708	64	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,492	5,162		8,033	32,450	20,361	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		658			10,247	1,742	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	50,571	42,134	157,060	91,745	190,146	473,308	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		230					190

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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		102				21	194
194.0 1	PHYSIATRY CLINIC		132					194.0 1
194.0 2	JANESVILLE MED CTR		986				5	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS		1,712				69	194.0 3
194.0 4	ASSISTED LIVING CENTERS		18,674				89	194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER		11,180				9	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	50,571	75,150	157,060	91,745	190,146	473,501	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	339,371						15
16	Medical Records & Library		331,431					16
17	Social Service			31,045				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	31	12,537	31,045	1,603,532		1,603,532	30
31	Intensive Care Unit	5	5,398		235,251		235,251	31
43	Nursery		1,080		11,874		11,874	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,156	19,012		720,227		720,227	50
51	Recovery Room	8	1,276		46,646		46,646	51
52	Delivery Room & Labor Room		2,694		29,069		29,069	52
53	Anesthesiology	1,406	2,470		54,044		54,044	53
54	Radiology-Diagnostic	156	11,290		617,511		617,511	54
55	Radiology-Therapeutic		6,767		254,528		254,528	55
57	CT Scan	84	24,008		249,187		249,187	57
58	MRI	40	12,200		154,376		154,376	58
59	Cardiac Catheterization	1,373	8,188		577,258		577,258	59
60	Laboratory	1	53,751		837,554		837,554	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,865		151,066		151,066	65
66	Physical Therapy		8,371		466,208		466,208	66
67	Occupational Therapy		1,509		26,697		26,697	67
68	Speech Pathology	1	319		17,716		17,716	68
69	Electrocardiology		8,484		44,189		44,189	69
71	Medical Supplies Charged to Patients		53,353		549,037		549,037	71
73	Drugs Charged to Patients	300,210	35,228		761,957		761,957	73
74	Renal Dialysis	21,635	8,637		417,239		417,239	74
75	ASC (Non-Distinct Part)	8	1,411		201,805		201,805	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		1,130		41,392		41,392	76.01
76.02	GI	490	8,754		278,265		278,265	76.02
76.03	NUCLEAR MED	10,090	5,169		60,604		60,604	76.03
76.04	PSYCH		2,157		210,219		210,219	76.04
76.05	ULTRASOUND	17	5,800		166,143		166,143	76.05
76.06	VASCULAR LAB		4,402		201,464		201,464	76.06
76.07	MEDICAL OUTPATIENT	132	470		46,095		46,095	76.07
76.97	CARDIAC REHABILITATION		610		58,784		58,784	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		24		2,393		2,393	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	97	21,028		1,362,602		1,362,602	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	77	1,039		144,393		144,393	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	338,017	331,431	31,045	10,599,325		10,599,325	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				34,809		34,809	190

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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				16,830		16,830	194
194.0 1	PHYSIATRY CLINIC				25,274		25,274	194.0 1
194.0 2	JANESVILLE MED CTR	74			112,351		112,351	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	1,266			237,085		237,085	194.0 3
194.0 4	ASSISTED LIVING CENTERS	10			1,978,040		1,978,040	194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER	4			1,243,907		1,243,907	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	339,371	331,431	31,045	14,247,621		14,247,621	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	585,014						1
2	Cap Rel Costs-Mvble Equip		4,256,217					2
4	Employee Benefits Department			60,312,650				4
5	Administrative & General	167,255	1,235,366	11,854,716	-31,630,851	123,698,389		5
6	Maintenance & Repairs							6
7	Operation of Plant	32,641	81,919	1,743,282		7,658,705	385,118	7
8	Laundry & Linen Service	1,554		56,178		649,660	1,554	8
9	Housekeeping	455	2,747	1,267,925		1,923,182	455	9
10	Dietary	4,662	9,991	882,711		1,753,893	4,662	10
11	Cafeteria	4,324	2,124	90,406		232,340	4,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,808	92,670	1,354,904		1,567,601	1,808	13
14	Central Services & Supply	7,993	244,132	599,564		1,634,710	7,993	14
15	Pharmacy	2,652	170,622	1,782,673		2,968,924	2,652	15
16	Medical Records & Library	10,198	103	2,409,832		3,943,536	10,198	16
17	Social Service	495		422,337		625,515	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	107,121	7,083,452		11,316,463	42,084	30
31	Intensive Care Unit	3,595	14,587	1,842,668		2,975,061	3,595	31
43	Nursery			180,677		261,783		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,703	217,419	1,871,599		4,004,755	11,703	50
51	Recovery Room	1,278		345,344		528,087	1,278	51
52	Delivery Room & Labor Room			446,377		646,757		52
53	Anesthesiology	485	22,551	65,201		272,080	485	53
54	Radiology-Diagnostic	13,817	218,738	1,477,163		2,880,151	13,817	54
55	Radiology-Therapeutic	6,786	71,405	386,802		1,204,731	6,786	55
57	CT Scan	1,328	122,336	854,843		1,916,831	1,328	57
58	MRI	948	85,081	346,521		929,826	948	58
59	Cardiac Catheterization	4,023	270,894	1,417,439		2,998,749	4,023	59
60	Laboratory	14,918	164,469	2,974,726		9,468,392	14,918	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,490	44,021	782,591		1,488,804	2,490	65
66	Physical Therapy	15,787	42,172	2,513,722		2,968,419	15,787	66
67	Occupational Therapy	796		237,629		293,204	796	67
68	Speech Pathology	455	345	145,658		225,748	455	68
69	Electrocardiology	490	10,954	249,103		382,560	490	69
71	Medical Supplies Charged to Patients					10,219,088		71
73	Drugs Charged to Patients					12,888,405		73
74	Renal Dialysis	7,057	65,447	1,195,700		3,944,120	7,057	74
75	ASC (Non-Distinct Part)	7,901	13,599	448,706		807,245	7,901	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	676	11,409	224,075		368,679	676	76.01
76.02	GI	3,087	123,685	690,538		1,436,459	3,087	76.02
76.03	NUCLEAR MED	781	7,106	285,497		672,259	781	76.03
76.04	PSYCH	6,288	2,479	1,631,804		2,523,015	6,288	76.04
76.05	ULTRASOUND	1,557	94,736	441,839		778,945	1,557	76.05
76.06	VASCULAR LAB	1,996	113,874	491,615		913,279	1,996	76.06
76.07	MEDICAL OUTPATIENT	1,000	2,404	342,351		525,801	1,000	76.07
76.97	CARDIAC REHABILITATION	1,683	12,194	193,014		328,595	1,683	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					71,600		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	26,315	490,596	4,017,850		7,253,558	26,315	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,356		1,227,073		2,050,167	3,356	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	416,717	4,169,296	56,876,105	-31,630,851	112,501,682	216,821	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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 DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
190	Gift, Flower, Coffee Shop & Canteen	1,172	7,060	44,969		149,844	1,172	190
194	PATHOLOGY	519	4,933	19,723		49,020	519	194
194.0 1	PHYSIATRY CLINIC	674		252,824		378,719	674	194.0 1
194.0 2	JANESVILLE MED CTR	5,027	4,597	160,504		369,628	5,027	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	8,727	2,858	1,164,073		2,044,524	8,727	194.0 3
194.0 4	ASSISTED LIVING CENTERS	95,183	24,458	1,528,275		4,591,414	95,183	194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER	56,995	43,015	266,177		3,613,558	56,995	194.0 5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	9,609,293	4,638,328	27,074,448		31,630,851	9,617,105	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.425749	1.089777	0.448902		0.255709	24.971840	203
204	Cost to be allocated (Per Wkst. B, Part II)					4,093,554	878,876	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.033093	2.282095	205

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	
	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	533,000						8
9	Housekeeping		383,109					9
10	Dietary		4,662	17,100				10
11	Cafeteria		4,324		651			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,808			22	334	13
14	Central Services & Supply		7,993				8,466,503	14
15	Pharmacy		2,652			21	37,324	15
16	Medical Records & Library		10,198			57		16
17	Social Service		495			7		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	236,800	42,084	14,997	128	128	393,622	30
31	Intensive Care Unit	29,800	3,595	2,103	28	28	98,479	31
43	Nursery				3	3		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	77,800	11,703		29	29	1,437,245	50
51	Recovery Room		1,278		4	4	15,822	51
52	Delivery Room & Labor Room				7	7		52
53	Anesthesiology		485		1	1	119,984	53
54	Radiology-Diagnostic	44,200	13,817		26		59,388	54
55	Radiology-Therapeutic		6,786		5		19,489	55
57	CT Scan		1,328		11		30,177	57
58	MRI		948		4		2,872	58
59	Cardiac Catheterization		4,023		18		1,692,534	59
60	Laboratory		14,918		60		13,682	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,490		12		39,297	65
66	Physical Therapy	12,300	15,787		35		162,862	66
67	Occupational Therapy		796		3		246	67
68	Speech Pathology		455		2		11,914	68
69	Electrocardiology		490		7		15,348	69
71	Medical Supplies Charged to Patients						2,816,245	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	19,700	7,057		22	22	611,904	74
75	ASC (Non-Distinct Part)	16,500	7,901		6	6	65,499	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		676		4	4	124	76.01
76.02	GI		3,087		13	13	341,618	76.02
76.03	NUCLEAR MED		781		3		2,988	76.03
76.04	PSYCH		6,288		21		676	76.04
76.05	ULTRASOUND		1,557		5		20,899	76.05
76.06	VASCULAR LAB	6,400	1,996		6	6	2,495	76.06
76.07	MEDICAL OUTPATIENT		1,000		5	5	53,959	76.07
76.97	CARDIAC REHABILITATION		1,683		3	3	1,137	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	89,500	26,315		57	57	364,067	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		3,356			18	31,149	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	533,000	214,812	17,100	651	334	8,463,045	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,172					190

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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				379	194
194.0 1	PHYSIATRY CLINIC		674				3	194.0 1
194.0 2	JANESVILLE MED CTR		5,027				96	194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS		8,727				1,239	194.0 3
194.0 4	ASSISTED LIVING CENTERS		95,183				1,584	194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER		56,995				157	194.0 5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	854,590	2,426,319	2,348,324	427,114	2,039,484	2,313,439	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.603358	6.333234	137.328889	656.089094	6,106.239521	0.273246	203
204	Cost to be allocated (Per Wkst. B, Part II)	50,571	75,150	157,060	91,745	190,146	473,501	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.094880	0.196158	9.184795	140.929339	569.299401	0.055926	205

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE				
	COSTED REQUIS.	GROSS REVENUE	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	13,766,311					15
16	Medical Records & Library		574,589,776				16
17	Social Service			13,174			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,252	21,728,755	13,174			30
31	Intensive Care Unit	189	9,355,245				31
43	Nursery		1,872,227				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	87,473	32,949,063				50
51	Recovery Room	313	2,212,025				51
52	Delivery Room & Labor Room		4,669,792				52
53	Anesthesiology	57,026	4,281,042				53
54	Radiology-Diagnostic	6,319	19,566,359				54
55	Radiology-Therapeutic		11,727,833				55
57	CT Scan	3,421	41,608,773				57
58	MRI	1,620	21,143,743				58
59	Cardiac Catheterization	55,685	14,190,763				59
60	Laboratory	59	93,337,947				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		4,965,920				65
66	Physical Therapy		14,508,410				66
67	Occupational Therapy		2,615,332				67
68	Speech Pathology	22	553,437				68
69	Electrocardiology		14,703,163				69
71	Medical Supplies Charged to Patients		92,465,432				71
73	Drugs Charged to Patients	12,177,721	61,053,599				73
74	Renal Dialysis	877,617	14,969,567				74
75	ASC (Non-Distinct Part)	334	2,444,629				75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG		1,959,153				76.01
76.02	GI	19,893	15,172,144				76.02
76.03	NUCLEAR MED	409,308	8,958,125				76.03
76.04	PSYCH		3,738,849				76.04
76.05	ULTRASOUND	686	10,051,206				76.05
76.06	VASCULAR LAB		7,628,507				76.06
76.07	MEDICAL OUTPATIENT	5,367	815,095				76.07
76.97	CARDIAC REHABILITATION		1,057,331				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY		42,180				76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic						90
91	Emergency	3,950	36,444,289				91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,106	1,799,841				101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,711,361	574,589,776	13,174			118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17				
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.0 1	PHYSIATRY CLINIC							194.0 1
194.0 2	JANESVILLE MED CTR	3,004						194.0 2
194.0 3	OCCUPATIONAL HEALTH & WELLNESS	51,363						194.0 3
194.0 4	ASSISTED LIVING CENTERS	416						194.0 4
194.0 5	NORTHPOINTE FITNESS AND SPA CENTER	167						194.0 5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,835,103	5,308,580	805,554				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.278586	0.009239	61.147260				203
204	Cost to be allocated (Per Wkst. B, Part II)	339,371	331,431	31,045				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.024652	0.000577	2.356536				205

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
				1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	19,946,617		19,946,617		19,946,617	30
31	Intensive Care Unit	4,487,676		4,487,676		4,487,676	31
43	Nursery	366,308		366,308		366,308	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,437,525		6,437,525		6,437,525	50
51	Recovery Room	755,028		755,028		755,028	51
52	Delivery Room & Labor Room	902,620		902,620		902,620	52
53	Anesthesiology	451,823		451,823		451,823	53
54	Radiology-Diagnostic	4,335,862		4,335,862		4,335,862	54
55	Radiology-Therapeutic	1,842,186		1,842,186		1,842,186	55
57	CT Scan	2,849,395		2,849,395		2,849,395	57
58	MRI	1,396,475		1,396,475		1,396,475	58
59	Cardiac Catheterization	4,512,406		4,512,406		4,512,406	59
60	Laboratory	13,261,968		13,261,968		13,261,968	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,011,946		2,011,946		2,011,946	65
66	Physical Therapy	4,442,911		4,442,911		4,442,911	66
67	Occupational Therapy	419,296		419,296		419,296	67
68	Speech Pathology	307,404		307,404		307,404	68
69	Electrocardiology	640,353		640,353		640,353	69
71	Medical Supplies Charged to Patients	14,456,016		14,456,016		14,456,016	71
73	Drugs Charged to Patients	20,140,762		20,140,762		20,140,762	73
74	Renal Dialysis	5,903,940		5,903,940		5,903,940	74
75	ASC (Non-Distinct Part)	1,368,612		1,368,612		1,368,612	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	529,300		529,300		529,300	76.01
76.02	GI	2,227,386		2,227,386		2,227,386	76.02
76.03	NUCLEAR MED	1,068,186		1,068,186		1,068,186	76.03
76.04	PSYCH	3,413,525		3,413,525		3,413,525	76.04
76.05	ULTRASOUND	1,128,915		1,128,915		1,128,915	76.05
76.06	VASCULAR LAB	1,331,295		1,331,295		1,331,295	76.06
76.07	MEDICAL OUTPATIENT	749,139		749,139		749,139	76.07
76.97	CARDIAC REHABILITATION	495,674		495,674		495,674	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	90,299		90,299		90,299	76.99
OUTPATIENT SERVICE COST CENTERS							
90	Clinic				300,474	300,474	90
91	Emergency	10,898,394		10,898,394		10,898,394	91
92	Observation Beds (Non-Distinct Part)	1,054,394		1,054,394		1,054,394	92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,815,389		2,815,389		2,815,389	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	137,039,025		137,039,025	300,474	137,339,499	200
201	Less Observation Beds	1,054,394		1,054,394		1,054,394	201
202	Total (line 200 minus line 201)	135,984,631		135,984,631		136,285,105	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	20,666,891		20,666,891				30
31	Intensive Care Unit	9,355,245		9,355,245				31
43	Nursery	1,872,227		1,872,227				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,792,914	20,156,149	32,949,063	0.195378	0.195378	0.195378	50
51	Recovery Room	770,483	1,441,542	2,212,025	0.341329	0.341329	0.341329	51
52	Delivery Room & Labor Room	3,429,866	1,239,926	4,669,792	0.193289	0.193289	0.193289	52
53	Anesthesiology	1,909,823	2,371,219	4,281,042	0.105540	0.105540	0.105540	53
54	Radiology-Diagnostic	3,140,285	16,426,074	19,566,359	0.221598	0.221598	0.221598	54
55	Radiology-Therapeutic	227,426	11,500,407	11,727,833	0.157078	0.157078	0.157078	55
57	CT Scan	8,389,022	33,219,751	41,608,773	0.068481	0.068481	0.068481	57
58	MRI	2,898,106	18,245,637	21,143,743	0.066047	0.066047	0.066047	58
59	Cardiac Catheterization	6,262,004	7,928,759	14,190,763	0.317982	0.317982	0.317982	59
60	Laboratory	22,971,004	70,366,943	93,337,947	0.142085	0.142085	0.142085	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,937,937	2,027,983	4,965,920	0.405151	0.405151	0.405151	65
66	Physical Therapy	1,704,832	12,803,578	14,508,410	0.306230	0.306230	0.306230	66
67	Occupational Therapy	751,301	1,864,031	2,615,332	0.160322	0.160322	0.160322	67
68	Speech Pathology	166,340	387,097	553,437	0.555445	0.555445	0.555445	68
69	Electrocardiology	3,962,504	10,740,659	14,703,163	0.043552	0.043552	0.043552	69
71	Medical Supplies Charged to Patients	51,793,436	40,671,996	92,465,432	0.156340	0.156340	0.156340	71
73	Drugs Charged to Patients	17,497,209	43,556,390	61,053,599	0.329887	0.329887	0.329887	73
74	Renal Dialysis	938,427	14,031,140	14,969,567	0.394396	0.394396	0.394396	74
75	ASC (Non-Distinct Part)		2,444,629	2,444,629	0.559844	0.559844	0.559844	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	75,056	1,884,097	1,959,153	0.270168	0.270168	0.270168	76.01
76.02	GI	1,418,114	13,754,030	15,172,144	0.146808	0.146808	0.146808	76.02
76.03	NUCLEAR MED	1,135,934	7,822,191	8,958,125	0.119242	0.119242	0.119242	76.03
76.04	PSYCH	17,454	3,721,395	3,738,849	0.912988	0.912988	0.912988	76.04
76.05	ULTRASOUND	908,440	9,142,766	10,051,206	0.112316	0.112316	0.112316	76.05
76.06	VASCULAR LAB	2,717,289	4,911,218	7,628,507	0.174516	0.174516	0.174516	76.06
76.07	MEDICAL OUTPATIENT		815,095	815,095	0.919082	0.919082	0.919082	76.07
76.97	CARDIAC REHABILITATION	2,843	1,054,488	1,057,331	0.468797	0.468797	0.468797	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		42,180	42,180	2.140801	2.140801	2.140801	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	5,974,378	30,469,911	36,444,289	0.299043	0.299043	0.299043	91
92	Observation Beds (Non-Distinct Part)		1,061,864	1,061,864	0.992965	0.992965	0.992965	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,799,841	1,799,841				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	186,686,790	387,902,986	574,589,776				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	186,686,790	387,902,986	574,589,776				202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	1,603,532		1,603,532	15,834	101.27	7,427	752,132	30
31	Intensive Care Unit	235,251		235,251	2,103	111.86	1,180	131,995	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	11,874		11,874	1,146	10.36			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,850,657		1,850,657	19,083		8,607	884,127	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	720,227	32,949,063	0.021859	5,275,322	115,313	50
51	Recovery Room	46,646	2,212,025	0.021087	271,703	5,729	51
52	Delivery Room & Labor Room	29,069	4,669,792	0.006225	26,665	166	52
53	Anesthesiology	54,044	4,281,042	0.012624	756,397	9,549	53
54	Radiology-Diagnostic	617,511	19,566,359	0.031560	1,859,638	58,690	54
55	Radiology-Therapeutic	254,528	11,727,833	0.021703	41,056	891	55
57	CT Scan	249,187	41,608,773	0.005989	4,611,847	27,620	57
58	MRI	154,376	21,143,743	0.007301	1,625,708	11,869	58
59	Cardiac Catheterization	577,258	14,190,763	0.040678	3,023,667	122,997	59
60	Laboratory	837,554	93,337,947	0.008973	12,632,015	113,347	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	151,066	4,965,920	0.030421	1,751,393	53,279	65
66	Physical Therapy	466,208	14,508,410	0.032134	1,025,033	32,938	66
67	Occupational Therapy	26,697	2,615,332	0.010208	490,786	5,010	67
68	Speech Pathology	17,716	553,437	0.032011	104,964	3,360	68
69	Electrocardiology	44,189	14,703,163	0.003005	2,096,786	6,301	69
71	Medical Supplies Charged to Pat	549,037	92,465,432	0.005938	25,822,657	153,335	71
73	Drugs Charged to Patients	761,957	61,053,599	0.012480	8,929,412	111,439	73
74	Renal Dialysis	417,239	14,969,567	0.027872	674,126	18,789	74
75	ASC (Non-Distinct Part)	201,805	2,444,629	0.082550			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	41,392	1,959,153	0.021127	45,217	955	76.01
76.02	GI	278,265	15,172,144	0.018341	810,663	14,868	76.02
76.03	NUCLEAR MED	60,604	8,958,125	0.006765	615,351	4,163	76.03
76.04	PSYCH	210,219	3,738,849	0.056226	653	37	76.04
76.05	ULTRASOUND	166,143	10,051,206	0.016530	426,510	7,050	76.05
76.06	VASCULAR LAB	201,464	7,628,507	0.026409	1,075,661	28,407	76.06
76.07	MEDICAL OUTPATIENT	46,095	815,095	0.056552			76.07
76.97	CARDIAC REHABILITATION	58,784	1,057,331	0.055597	1,066	59	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	2,393	42,180	0.056733			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,362,602	36,444,289	0.037389	3,307,890	123,679	91
92	Observation Beds (Non-Distinct	84,764	1,061,864	0.079826			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,689,039	540,895,572		77,302,186	1,029,840	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	15,834		7,427		30
31	Intensive Care Unit	2,103		1,180		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	1,146				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,083		8,607		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID 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 Pat							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	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	32,949,063			5,275,322		6,663,173		50
51	Recovery Room	2,212,025			271,703		280,404		51
52	Delivery Room & Labor Room	4,669,792			26,665		8,300		52
53	Anesthesiology	4,281,042			756,397		541,064		53
54	Radiology-Diagnostic	19,566,359			1,859,638		4,896,252		54
55	Radiology-Therapeutic	11,727,833			41,056		4,255,601		55
57	CT Scan	41,608,773			4,611,847		10,226,936		57
58	MRI	21,143,743			1,625,708		5,117,391		58
59	Cardiac Catheterization	14,190,763			3,023,667		3,489,205		59
60	Laboratory	93,337,947			12,632,015		11,106,329		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,965,920			1,751,393		660,190		65
66	Physical Therapy	14,508,410			1,025,033		223,378		66
67	Occupational Therapy	2,615,332			490,786		18,589		67
68	Speech Pathology	553,437			104,964		1,471		68
69	Electrocardiology	14,703,163			2,096,786		3,499,415		69
71	Medical Supplies Charged to Pat	92,465,432			25,822,657		12,420,458		71
73	Drugs Charged to Patients	61,053,599			8,929,412		14,405,822		73
74	Renal Dialysis	14,969,567			674,126		17,943		74
75	ASC (Non-Distinct Part)	2,444,629							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	1,959,153			45,217		544,299		76.01
76.02	GI	15,172,144			810,663		4,176,271		76.02
76.03	NUCLEAR MED	8,958,125			615,351		3,281,371		76.03
76.04	PSYCH	3,738,849			653		757,187		76.04
76.05	ULTRASOUND	10,051,206			426,510		1,488,595		76.05
76.06	VASCULAR LAB	7,628,507			1,075,661		1,485,593		76.06
76.07	MEDICAL OUTPATIENT	815,095							76.07
76.97	CARDIAC REHABILITATION	1,057,331			1,066		497,574		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	42,180							76.99
OUTPATIENT SERVICE COST CENTERS									
90	Clinic								90
91	Emergency	36,444,289			3,307,890		5,923,117		91
92	Observation Beds (Non-Distinct)	1,061,864					364,027		92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	540,895,572			77,302,186		96,349,955		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	0.195378	6,663,173			1,301,837		50	
51	Recovery Room	0.341329	280,404			95,710		51	
52	Delivery Room & Labor Room	0.193289	8,300			1,604		52	
53	Anesthesiology	0.105540	541,064			57,104		53	
54	Radiology-Diagnostic	0.221598	4,896,252			1,085,000		54	
55	Radiology-Therapeutic	0.157078	4,255,601			668,461		55	
57	CT Scan	0.068481	10,226,936			700,351		57	
58	MRI	0.066047	5,117,391			337,988		58	
59	Cardiac Catheterization	0.317982	3,489,205			1,109,504		59	
60	Laboratory	0.142085	11,106,329	7,882		1,578,043	1,120	60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
65	Respiratory Therapy	0.405151	660,190			267,477		65	
66	Physical Therapy	0.306230	223,378			68,405		66	
67	Occupational Therapy	0.160322	18,589			2,980		67	
68	Speech Pathology	0.555445	1,471			817		68	
69	Electrocardiology	0.043552	3,499,415			152,407		69	
71	Medical Supplies Charged to Pat	0.156340	12,420,458	1,782		1,941,814	279	71	
73	Drugs Charged to Patients	0.329887	14,405,822	4,992	368,801	4,752,293	1,647	121,663	
74	Renal Dialysis	0.394396	17,943			7,077		74	
75	ASC (Non-Distinct Part)	0.559844						75	
76	OTHER ANCILLARY							76	
76.01	SLEEP/EEG	0.270168	544,299			147,052		76.01	
76.02	GI	0.146808	4,176,271			613,110		76.02	
76.03	NUCLEAR MED	0.119242	3,281,371			391,277		76.03	
76.04	PSYCH	0.912988	757,187			691,303		76.04	
76.05	ULTRASOUND	0.112316	1,488,595			167,193		76.05	
76.06	VASCULAR LAB	0.174516	1,485,593			259,260		76.06	
76.07	MEDICAL OUTPATIENT	0.919082						76.07	
76.97	CARDIAC REHABILITATION	0.468797	497,574			233,261		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY	2.140801						76.99	
OUTPATIENT SERVICE COST CENTERS									
90	Clinic							90	
91	Emergency	0.299043	5,923,117			1,771,267		91	
92	Observation Beds (Non-Distinct)	0.992965	364,027			361,466		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)		96,349,955	14,656	368,801	18,764,061	3,046	121,663	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		96,349,955	14,656	368,801	18,764,061	3,046	121,663	

(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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	1,603,532		1,603,532	15,834	101.27	900	91,143	30
31	Intensive Care Unit	235,251		235,251	2,103	111.86	50	5,593	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	11,874		11,874	1,146	10.36	232	2,404	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,850,657		1,850,657	19,083		1,182	99,140	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	8
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	720,227	32,949,063	0.021859	452,127	9,883	50
51	Recovery Room	46,646	2,212,025	0.021087	42,609	898	51
52	Delivery Room & Labor Room	29,069	4,669,792	0.006225	474,864	2,956	52
53	Anesthesiology	54,044	4,281,042	0.012624	78,894	996	53
54	Radiology-Diagnostic	617,511	19,566,359	0.031560	129,326	4,082	54
55	Radiology-Therapeutic	254,528	11,727,833	0.021703			55
57	CT Scan	249,187	41,608,773	0.005989	426,245	2,553	57
58	MRI	154,376	21,143,743	0.007301	141,091	1,030	58
59	Cardiac Catheterization	577,258	14,190,763	0.040678	178,828	7,274	59
60	Laboratory	837,554	93,337,947	0.008973	1,293,020	11,602	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	151,066	4,965,920	0.030421	149,411	4,545	65
66	Physical Therapy	466,208	14,508,410	0.032134	61,030	1,961	66
67	Occupational Therapy	26,697	2,615,332	0.010208	13,409	137	67
68	Speech Pathology	17,716	553,437	0.032011	4,057	130	68
69	Electrocardiology	44,189	14,703,163	0.003005	160,351	482	69
71	Medical Supplies Charged to Pat	549,037	92,465,432	0.005938	1,743,965	10,356	71
73	Drugs Charged to Patients	761,957	61,053,599	0.012480	812,939	10,145	73
74	Renal Dialysis	417,239	14,969,567	0.027872	21,981	613	74
75	ASC (Non-Distinct Part)	201,805	2,444,629	0.082550			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	41,392	1,959,153	0.021127	2,383	50	76.01
76.02	GI	278,265	15,172,144	0.018341	86,474	1,586	76.02
76.03	NUCLEAR MED	60,604	8,958,125	0.006765	52,053	352	76.03
76.04	PSYCH	210,219	3,738,849	0.056226	2,923	164	76.04
76.05	ULTRASOUND	166,143	10,051,206	0.016530	61,386	1,015	76.05
76.06	VASCULAR LAB	201,464	7,628,507	0.026409	140,289	3,705	76.06
76.07	MEDICAL OUTPATIENT	46,095	815,095	0.056552			76.07
76.97	CARDIAC REHABILITATION	58,784	1,057,331	0.055597			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	2,393	42,180	0.056733			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,362,602	36,444,289	0.037389	377,567	14,117	91
92	Observation Beds (Non-Distinct	84,764	1,061,864	0.079826			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	8,689,039	540,895,572		6,907,222	90,632	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	15,834		900		30
31	Intensive Care Unit	2,103		50		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	1,146		232		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,083		1,182		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID 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 Pat							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	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	32,949,063			452,127				50
51	Recovery Room	2,212,025			42,609				51
52	Delivery Room & Labor Room	4,669,792			474,864				52
53	Anesthesiology	4,281,042			78,894				53
54	Radiology-Diagnostic	19,566,359			129,326				54
55	Radiology-Therapeutic	11,727,833							55
57	CT Scan	41,608,773			426,245				57
58	MRI	21,143,743			141,091				58
59	Cardiac Catheterization	14,190,763			178,828				59
60	Laboratory	93,337,947			1,293,020				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,965,920			149,411				65
66	Physical Therapy	14,508,410			61,030				66
67	Occupational Therapy	2,615,332			13,409				67
68	Speech Pathology	553,437			4,057				68
69	Electrocardiology	14,703,163			160,351				69
71	Medical Supplies Charged to Pat	92,465,432			1,743,965				71
73	Drugs Charged to Patients	61,053,599			812,939				73
74	Renal Dialysis	14,969,567			21,981				74
75	ASC (Non-Distinct Part)	2,444,629							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	1,959,153			2,383				76.01
76.02	GI	15,172,144			86,474				76.02
76.03	NUCLEAR MED	8,958,125			52,053				76.03
76.04	PSYCH	3,738,849			2,923				76.04
76.05	ULTRASOUND	10,051,206			61,386				76.05
76.06	VASCULAR LAB	7,628,507			140,289				76.06
76.07	MEDICAL OUTPATIENT	815,095							76.07
76.97	CARDIAC REHABILITATION	1,057,331							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	42,180							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	36,444,289			377,567				91
92	Observation Beds (Non-Distinct)	1,061,864							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	540,895,572			6,907,222				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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.195378		653,735			127,725		50
51	Recovery Room	0.341329		62,787			21,431		51
52	Delivery Room & Labor Room	0.193289		129,685			25,067		52
53	Anesthesiology	0.105540		82,119			8,667		53
54	Radiology-Diagnostic	0.221598		778,234			172,455		54
55	Radiology-Therapeutic	0.157078		413,388			64,934		55
57	CT Scan	0.068481		2,096,611			143,578		57
58	MRI	0.066047		683,653			45,153		58
59	Cardiac Catheterization	0.317982		71,752			22,816		59
60	Laboratory	0.142085		3,837,794			545,293		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.405151		119,567			48,443		65
66	Physical Therapy	0.306230		320,531			98,156		66
67	Occupational Therapy	0.160322		47,177			7,564		67
68	Speech Pathology	0.555445		44,455			24,692		68
69	Electrocardiology	0.043552		330,208			14,381		69
71	Medical Supplies Charged to Pat	0.156340		1,362,571			213,024		71
73	Drugs Charged to Patients	0.329887		2,305,979			760,712		73
74	Renal Dialysis	0.394396		670,268			264,351		74
75	ASC (Non-Distinct Part)	0.559844							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	0.270168		58,493			15,803		76.01
76.02	GI	0.146808		255,387			37,493		76.02
76.03	NUCLEAR MED	0.119242		179,593			21,415		76.03
76.04	PSYCH	0.912988		333,714			304,677		76.04
76.05	ULTRASOUND	0.112316		745,198			83,698		76.05
76.06	VASCULAR LAB	0.174516		150,956			26,344		76.06
76.07	MEDICAL OUTPATIENT	0.919082							76.07
76.97	CARDIAC REHABILITATION	0.468797							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	2.140801							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	0.299043		3,576,729			1,069,596		91
92	Observation Beds (Non-Distinct)	0.992965		54,691			54,306		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			19,365,275			4,221,774		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			19,365,275			4,221,774		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,834	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,834	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)	14,997	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)	7,427	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)	19,946,617	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)	19,946,617	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)	19,946,617	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)						1,259.73	38
39	Program general inpatient routine service cost (line 9 x line 38)						9,356,015	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						9,356,015	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	4,487,676	2,103	2,133.94	1,180	2,518,049		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)						14,737,425	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						26,611,489	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						884,127	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						1,029,840	51
52	Total Program excludable cost (sum of lines 50 and 51)						1,913,967	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						24,697,522	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					837	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,259.73	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,054,394	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,603,532	19,946,617	0.080391	1,054,394	84,764	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,834	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,834	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)	14,997	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)	900	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)	1,146	15
16	Nursery days (title V or XIX only)	232	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)	19,946,617	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)	19,946,617	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)	19,946,617	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)						1,259.73	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,133,757	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						1,133,757	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)	366,308	1,146	319.64	232	74,156		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	4,487,676	2,103	2,133.94	50	106,697		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)						1,317,352	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						2,631,962	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						99,140	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						90,632	51
52	Total Program excludable cost (sum of lines 50 and 51)						189,772	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					837	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 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 52-0100

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,939,719		30
31	Intensive Care Unit		5,200,763		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.195378	5,275,322	1,030,682	50
51	Recovery Room	0.341329	271,703	92,740	51
52	Delivery Room & Labor Room	0.193289	26,665	5,154	52
53	Anesthesiology	0.105540	756,397	79,830	53
54	Radiology-Diagnostic	0.221598	1,859,638	412,092	54
55	Radiology-Therapeutic	0.157078	41,056	6,449	55
57	CT Scan	0.068481	4,611,847	315,824	57
58	MRI	0.066047	1,625,708	107,373	58
59	Cardiac Catheterization	0.317982	3,023,667	961,472	59
60	Laboratory	0.142085	12,632,015	1,794,820	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.405151	1,751,393	709,579	65
66	Physical Therapy	0.306230	1,025,033	313,896	66
67	Occupational Therapy	0.160322	490,786	78,684	67
68	Speech Pathology	0.555445	104,964	58,302	68
69	Electrocardiology	0.043552	2,096,786	91,319	69
71	Medical Supplies Charged to Patients	0.156340	25,822,657	4,037,114	71
73	Drugs Charged to Patients	0.329887	8,929,412	2,945,697	73
74	Renal Dialysis	0.394396	674,126	265,873	74
75	ASC (Non-Distinct Part)	0.559844			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.270168	45,217	12,216	76.01
76.02	GI	0.146808	810,663	119,012	76.02
76.03	NUCLEAR MED	0.119242	615,351	73,376	76.03
76.04	PSYCH	0.912988	653	596	76.04
76.05	ULTRASOUND	0.112316	426,510	47,904	76.05
76.06	VASCULAR LAB	0.174516	1,075,661	187,720	76.06
76.07	MEDICAL OUTPATIENT	0.919082			76.07
76.97	CARDIAC REHABILITATION	0.468797	1,066	500	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	2.140801			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.299043	3,307,890	989,201	91
92	Observation Beds (Non-Distinct Part)	0.992965			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		77,302,186	14,737,425	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		77,302,186		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,215,276		30
31	Intensive Care Unit		456,927		31
43	Nursery		412,961		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.195378	452,127	88,336	50
51	Recovery Room	0.341329	42,609	14,544	51
52	Delivery Room & Labor Room	0.193289	474,864	91,786	52
53	Anesthesiology	0.105540	78,894	8,326	53
54	Radiology-Diagnostic	0.221598	129,326	28,658	54
55	Radiology-Therapeutic	0.157078			55
57	CT Scan	0.068481	426,245	29,190	57
58	MRI	0.066047	141,091	9,319	58
59	Cardiac Catheterization	0.317982	178,828	56,864	59
60	Laboratory	0.142085	1,293,020	183,719	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.405151	149,411	60,534	65
66	Physical Therapy	0.306230	61,030	18,689	66
67	Occupational Therapy	0.160322	13,409	2,150	67
68	Speech Pathology	0.555445	4,057	2,253	68
69	Electrocardiology	0.043552	160,351	6,984	69
71	Medical Supplies Charged to Patients	0.156340	1,743,965	272,651	71
73	Drugs Charged to Patients	0.329887	812,939	268,178	73
74	Renal Dialysis	0.394396	21,981	8,669	74
75	ASC (Non-Distinct Part)	0.559844			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.270168	2,383	644	76.01
76.02	GI	0.146808	86,474	12,695	76.02
76.03	NUCLEAR MED	0.119242	52,053	6,207	76.03
76.04	PSYCH	0.912988	2,923	2,669	76.04
76.05	ULTRASOUND	0.112316	61,386	6,895	76.05
76.06	VASCULAR LAB	0.174516	140,289	24,483	76.06
76.07	MEDICAL OUTPATIENT	0.919082			76.07
76.97	CARDIAC REHABILITATION	0.468797			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	2.140801			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.299043	377,567	112,909	91
92	Observation Beds (Non-Distinct Part)	0.992965			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,907,222	1,317,352	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,907,222		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	11,400,819			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,241,209			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)	1,017,620			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)	100.71			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)	0.0540			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1957			31
32	Sum of lines 30 and 31	0.2497			32
33	Allowable disproportionate share percentage (see instructions)	0.0982			33
34	Disproportionate share adjustment (see instructions)	359,462			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	6,406,145,534		5,977,483,147	35
35.01	Factor 3 (see instructions)	0.000101317		0.000103426	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	649,051		618,227	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	485,902		155,827	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	641,729			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

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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)	16,660,839			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)	16,660,839			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,311,962			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	3,107			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)	17,975,908			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	17,975,908			61
62	Deductibles billed to program beneficiaries	1,794,632			62
63	Coinsurance billed to program beneficiaries	26,726			63
64	Allowable bad debts (see instructions)	320,737			64
65	Adjusted reimbursable bad debts (see instructions)	208,479			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	320,737			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,363,029			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)	-1,276			70.93
70.94	HRR adjustment amount (see instructions)	-88,123			70.94
71	Amount due provider (see instructions)	16,273,630			71
71.01	Sequestration adjustment (see instructions)	325,473			71.01
72	Interim payments	15,796,281			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	151,876			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
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

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

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	124,709			1
2	Medical and other services reimbursed under OPPS (see instructions)	18,764,061			2
3	PPS payments	22,389,560			3
4	Outlier payment (see instructions)	262,772			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.872			5
6	Line 2 times line 5	16,362,261			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	124,709			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	383,457			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)	383,457			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)	383,457			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	258,748			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)	124,709			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)	22,652,332			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,902,606			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)	17,874,435			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)	17,874,435			30
31	Primary payer payments	1,764			31
32	Subtotal (line 30 minus line 31)	17,872,671			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)	662,045			34
35	Adjusted reimbursable bad debts (see instructions)	430,329			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	662,045			36
37	Subtotal (see instructions)	18,303,000			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	18,303,000			40
40.01	Sequestration adjustment (see instructions)	366,060			40.01
41	Interim payments	17,392,989			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	543,951			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	Total interim payments paid to provider		15,796,281		17,392,989	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)		15,796,281		17,392,989	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**WORKSHEET E-1
PART II**

Check [XX] 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)	4,150	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	8,607	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,684	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	17,100	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	574,589,776	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,486,652	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)	392,240	8
9	Sequestration adjustment amount (see instructions)	7,845	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	384,395	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	384,000	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	395	32

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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/IID 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	Inpatient hospital/SNF/NF services	2,631,962		1
2	Medical and other services		4,221,774	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,631,962	4,221,774	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,631,962	4,221,774	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	6,907,222	19,365,275	9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	6,907,222	19,365,275	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	6,907,222	19,365,275	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,275,260	15,143,501	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	2,631,962	4,221,774	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	2,631,962	4,221,774	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,631,962	4,221,774	31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	2,631,962	4,221,774	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,631,962	4,221,774	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	2,631,962	4,221,774	40
41	Interim payments	2,989,747	3,821,733	41
42	Balance due provider/program (line 40 minus line 41)	-357,785	400,041	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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BALANCE SHEET

WORKSHEET G

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

	Assets (Omit Cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS						
1	Cash on hand and in banks	22,760,348				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	48,849,923				4
5	Other receivables	3,213,902				5
6	Allowances for uncollectible notes and accounts receivable	-13,108,000				6
7	Inventory	4,430,933				7
8	Prepaid expenses	985,580				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	67,132,686				11
FIXED ASSETS						
12	Land	8,100,877				12
13	Land improvements	6,300,943				13
14	Accumulated depreciation	-4,785,786				14
15	Buildings	121,649,868				15
16	Accumulated depreciation	-51,869,877				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	41,231,969				19
20	Accumulated depreciation	-23,885,023				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	63,931,169				23
24	Accumulated depreciation	-52,797,802				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)	107,876,338				30
OTHER ASSETS						
31	Investments	71,291,138				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	23,628,436				34
35	Total other assets (sum of lines 31-34)	94,919,574				35
36	Total assets (sum of lines 11, 30 and 35)	269,928,598				36

	Liabilities and Fund Balances (Omit Cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT LIABILITIES						
37	Accounts payable	11,358,859				37
38	Salaries, wages and fees payable	5,696,158				38
39	Payroll taxes payable	1,343,073				39
40	Notes and loans payable (short term)	2,776,639				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	11,907,488				44
45	Total current liabilities (sum of lines 37 thru 44)	33,082,217				45
LONG TERM LIABILITIES						
46	Mortgage payable	84,584,834				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	28,360,187				49
50	Total long term liabilities (sum of lines 46 thru 49)	112,945,021				50
51	Total liabilities (sum of lines 45 and 50)	146,027,238				51
CAPITAL ACCOUNTS						
52	General fund balance	123,901,360				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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	123,901,360				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	269,928,598				60

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		109,512,161			1
2	Net income (loss) (from Worksheet G-3, line 29)		10,357,406			2
3	Total (sum of line 1 and line 2)		119,869,567			3
4	Additions (credit adjustments) (specify)					4
5	ASSETS RELEASED FROM RESTRICTIONS	2,662,121				5
6	NET ASSETS BELOIT REGIONAL HOSPICE	578,730				6
7	CHANGE IN SWAP VALUE	1,097,089				7
8	CHANGE IN UNREALIZED GAINS / LOSSES	1,973,312				8
9						9
10	Total additions (sum of lines 4-9)		6,311,252			10
11	Subtotal (line 3 plus line 10)		126,180,819			11
12	Deductions (debit adjustments) (specify)					12
13	CHANGE IN PENSION OBLIGATION	2,229,810				13
14	FOUNDATION RECEIVABLE WRITEDOWN	49,640				14
15	OTHER	9				15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,279,459			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		123,901,360			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	NET ASSETS BELOIT REGIONAL HOSPICE					6
7	CHANGE IN SWAP VALUE					7
8	CHANGE IN UNREALIZED GAINS / LOSSES					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 PENSION OBLIGATION					13
14	FOUNDATION RECEIVABLE WRITEDOWN					14
15	OTHER					15
16						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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	21,833,822		21,833,822	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)	21,833,822		21,833,822	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	9,086,348		9,086,348	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)	9,086,348		9,086,348	16
17	Total inpatient routine care services (sum of lines 10 and 16)	30,920,170		30,920,170	17
18	Ancillary services	156,229,428	563,049,612	719,279,040	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		1,799,841	1,799,841	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)	187,149,598	564,849,453	751,999,051	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		222,975,669	29
30	Add (specify)			30
31	HOSPICE FILED ON FORM 1984-14	3,434,580		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		3,434,580	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)		226,410,249	43

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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)	751,999,051	1
2	Less contractual allowances and discounts on patients' accounts	526,771,338	2
3	Net patient revenues (line 1 minus line 2)	225,227,713	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	226,410,249	4
5	Net income from service to patients (line 3 minus line 4)	-1,182,536	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)	8,547,171	24
24.0	Other (NONOPERATING INCOME - NET)	2,992,771	24.0
1			1
25	Total other income (sum of lines 6-24)	11,539,942	25
26	Total (line 5 plus line 25)	10,357,406	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,357,406	29

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	151,324				170,447	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	611,625		27,313			6
7	Physical Therapy	314,817		14,059			7
8	Occupational Therapy	110,053		4,915			8
9	Speech Pathology	2,137					9
10	Medical Social Services	304					10
11	Home Health Aide	36,813		1,753			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)	1,227,073		48,040		170,447	24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	321,771		321,771	-1,354	320,417	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	638,938		638,938		638,938	6
7	Physical Therapy	328,876		328,876		328,876	7
8	Occupational Therapy	114,968		114,968		114,968	8
9	Speech Pathology	2,137		2,137		2,137	9
10	Medical Social Services	304		304		304	10
11	Home Health Aide	38,566		38,566		38,566	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)	1,445,560		1,445,560	-1,354	1,444,206	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	320,417				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	638,938				6
7	Physical Therapy	328,876				7
8	Occupational Therapy	114,968				8
9	Speech Pathology	2,137				9
10	Medical Social Services	304				10
11	Home Health Aide	38,566				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)	1,444,206				24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		320,417	320,417		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		638,938	182,175	821,113	6
7	Physical Therapy		328,876	93,770	422,646	7
8	Occupational Therapy		114,968	32,780	147,748	8
9	Speech Pathology		2,137	609	2,746	9
10	Medical Social Services		304	87	391	10
11	Home Health Aide		38,566	10,996	49,562	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)		1,444,206		1,444,206	24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General	3,356				-320,417	1,123,789	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						638,938	6
7	Physical Therapy						328,876	7
8	Occupational Therapy						114,968	8
9	Speech Pathology						2,137	9
10	Medical Social Services						304	10
11	Home Health Aide						38,566	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				-320,417	1,123,789	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						320,417	25
26	Unit Cost Multiplier						0.285122	26

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	55,125		67,930	123,055	31,466	1
2	Skilled Nursing Care	821,113			274,561	1,095,674	280,174	2
3	Physical Therapy	422,646			141,322	563,968	144,212	3
4	Occupational Therapy	147,748			49,403	197,151	50,413	4
5	Speech Pathology	2,746			959	3,705	947	5
6	Medical Social Services	391			136	527	135	6
7	Home Health Aide	49,562			16,525	66,087	16,899	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)	1,444,206	55,125		550,836	2,050,167	524,246	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General		83,805		21,254			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)		83,805		21,254			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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		109,912	8,511	865	16,629		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)		109,912	8,511	865	16,629		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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						395,497	1
2	Skilled Nursing Care						1,375,848	2
3	Physical Therapy						708,180	3
4	Occupational Therapy						247,564	4
5	Speech Pathology						4,652	5
6	Medical Social Services						662	6
7	Home Health Aide						82,986	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)						2,815,389	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		395,497				1
2	Skilled Nursing Care		1,375,848	224,863	1,600,711		2
3	Physical Therapy		708,180	115,742	823,922		3
4	Occupational Therapy		247,564	40,461	288,025		4
5	Speech Pathology		4,652	760	5,412		5
6	Medical Social Services		662	108	770		6
7	Home Health Aide		82,986	13,563	96,549		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)		2,815,389	395,497	2,815,389		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.			0.163436			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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		151,324		123,055		1
2	Skilled Nursing Care			611,625		1,095,674		2
3	Physical Therapy			314,817		563,968		3
4	Occupational Therapy			110,053		197,151		4
5	Speech Pathology			2,137		3,705		5
6	Medical Social Services			304		527		6
7	Home Health Aide			36,813		66,087		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		1,227,073		2,050,167		20
21	Total cost to be allocated	55,125		550,836		524,246		21
22	Unit Cost Multiplier	16.425805		0.448902		0.255709		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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	83,805		21,254				21
22	Unit Cost Multiplier	24.971692		6.333135				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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	18	31,149	3,106	1,799,841			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)	18	31,149	3,106	1,799,841			20
21	Total cost to be allocated	109,912	8,511	865	16,629			21
22	Unit Cost Multiplier	6,106.222222		0.278493				22
22	Unit Cost Multiplier		0.273235		0.009239			22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	1,600,711		1,600,711	4,891	327.28
2	Physical Therapy	3	823,922		823,922	2,716	303.36
3	Occupational Therapy	4	288,025		288,025	889	323.99
4	Speech Pathology	5	5,412		5,412	34	159.18
5	Medical Social Services	6	770		770	6	128.33
6	Home Health Aide	7	96,549		96,549	1,380	69.96
7	Total (sum of lines 1-6)		2,815,389		2,815,389	9,916	

Limitation Cost Computation				Program Visits	
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1	2	3	4
8	Skilled Nursing Care	27500		2,748	
8.01	Skilled Nursing Care	31540		23	
8.02	Skilled Nursing Care	40420		482	
8.03	Skilled Nursing Care	99952		32	
9	Physical Therapy	27500		1,629	
9.01	Physical Therapy	31540		33	
9.02	Physical Therapy	40420		143	
9.03	Physical Therapy	99952		19	
10	Occupational Therapy	27500		526	
10.01	Occupational Therapy	31540		13	
10.02	Occupational Therapy	40420		50	
10.03	Occupational Therapy	99952		8	
11	Speech Pathology	27500		23	
11.01	Speech Pathology	31540			
11.02	Speech Pathology	40420			
11.03	Speech Pathology	99952			
12	Medical Social Services	27500		4	
12.01	Medical Social Services	31540			
12.02	Medical Social Services	40420			
12.03	Medical Social Services	99952			
13	Home Health Aide	27500		849	
13.01	Home Health Aide	31540			
13.02	Home Health Aide	40420		78	
13.03	Home Health Aide	99952			
14	Total (sum of lines 8-13)			6,660	

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					
16	Cost of Drugs	9					

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

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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

		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	0.306230			col. 2, line 2	1
2	Occupational Therapy	67	0.160322			col. 2, line 3	2
3	Speech Pathology	68	0.555445			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.156340			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.329887			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		3,285			1,075,115		1,075,115	1
2	Physical Therapy		1,824			553,329		553,329	2
3	Occupational Therapy		597			193,422		193,422	3
4	Speech Pathology		23			3,661		3,661	4
5	Medical Social Services		4			513		513	5
6	Home Health Aide		927			64,853		64,853	6
7	Total (sum of lines 1-6)		6,660			1,890,893		1,890,893	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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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		1,024,679	11
12	Total PPS Reimbursement - Full Episodes with Outliers		47,217	12
13	Total PPS Reimbursement - LUPA Episodes		23,690	13
14	Total PPS Reimbursement - PEP Episodes		8,253	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			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)		1,103,839	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,103,839	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,103,839	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)		1,103,839	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,103,839	31
31.01	Sequestration adjustment (see instructions)		22,076	31.01
32	Interim payments (see instructions)		1,081,763	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			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				1,081,763	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)				1,081,763	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	575,507	Hours of Service	15,361.00	7.39	1
2	Licensed Practical Nurses	40,403	Hours of Service	1,713.00	0.82	2
3	Nurses Aides		Hours of Service			3
4	Technicians	445,360	Hours of Service	24,773.00	11.91	4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary	134,430	Accumulated Cost			8
9	Subtotal (sum of lines 1-8)	1,195,700				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	24,512	Percentage of Time			13
14	Supplies	769,626	Requisitions			14
15	Drugs	877,617	Requisitions			15
16	Other	352,673	Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*	3,220,128				17
18	Capital Related Costs-Bldgs. & Fixtures	115,917	Square Feet			18
19	Capital Related Costs-Mov. Equip.	71,323	Percentage of Time			19
20	Employee Benefits Department	536,752	Salary			20
21	Administrative and General	1,008,547	Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping	220,920	Square Feet			22
23	Medical Educatino Program Costs					23
24	Central Services & Supplies	167,200	Requisitions			24
25	Pharmacy	244,492	Requisitions			25
26	Other Allocated Costs	318,661	Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*	5,903,940				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)	5,903,940				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 24, less the sum of columns 21 and 22, 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	336,837	95,835	575,507	485,763	536,752	1,122,109	1
	MAINTENANCE							
2	Hemodialysis	197,130	56,088	336,836	284,287	314,140	656,726	2
3	Intermittent Peritoneal							3
	TRAINING							
4	Hemodialysis							4
5	Intermittent Peritoneal							5
6	CAPD	95	28	150	143	153	321	6
7	CCPD	1,575	448	2,698	2,280	2,513	5,252	7
	HOME							
8	Hemodialysis							8
9	Intermittent Peritoneal							9
10	CAPD	5,441	1,554	9,330	7,876	8,702	18,193	10
11	CCPD	123,432	35,113	210,869	177,976	196,659	411,125	11
	OTHER BILLABLE SERVICES							
12	Inpatient Dialysis	9,164	2,604	15,624	13,201	14,585	30,492	12
13	Method II Home Patient							13
14	All ESAs (incl. in renal department)							14
15	N/A for FYB on/after 10/1/2015							15
16	Other							16
17	Total (sum of lines 2 through 16)	336,837	95,835	575,507	485,763	536,752	1,122,109	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: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	936,826		4,089,629	1,814,311	5,903,940	1
	MAINTENANCE						
2	Hemodialysis	548,286		2,393,493	1,061,843	3,455,336	2
3	Intermittent Peritoneal						3
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	268		1,158	514	1,672	6
7	CCPD	4,385		19,151	8,496	27,647	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	15,189		66,285	29,406	95,691	10
11	CCPD	343,241		1,498,415	664,752	2,163,167	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis	25,457		111,127	49,300	160,427	12
13	Method II Home Patient						13
14	All ESAs (incl. in renal department)						14
15	N/A for FYB on/after 10/1/2015						15
16	Other						16
17	Total (sum of lines 2 through 16)	936,826		4,089,629	1,814,311	5,903,940	17
18	Medical Educational Program Costs						18
19	Total Renal Costs (line 17 + line 18)					5,903,940	19

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	336,837	95,835	575,507	485,763	536,752	1
	MAINTENANCE						
2	Hemodialysis	4,130	38,304.00	8,990.00	17,831.00	699,795	2
3	Intermittent Peritoneal						3
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	2	19.00	4.00	9.00	341	6
7	CCPD	33	306.00	72.00	143.00	5,597	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	114	1,061.00	249.00	494.00	19,386	10
11	CCPD	2,586	23,979.00	5,628.00	11,163.00	438,089	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 476	192	1,778.00	417.00	828.00	32,491	12
13	Method II Home Patient						13
14	N/A for FYB on/after 10/1/2015						14
15	N/A for FYB on/after 10/1/2015						15
16	Other						16
17	Total Statistical Basis	7,057	65,447.00	15,360.00	30,468.00	1,195,699	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	47.730905	1.464315	37.467904	15.943383	0.448902	18

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/19/2017 Run Time: 11:01 Version: 2017.01 (05/15/2017)
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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	1,122,109	936,826				1
	MAINTENANCE						
2	Hemodialysis	513,634	358,123				2
3	Intermittent Peritoneal						3
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	251	175				6
7	CCPD	4,108	2,864				7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	14,229	9,921				10
11	CCPD	321,547	224,194				11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 476	23,848	16,628				12
13	Method II Home Patient						13
14	N/A for FYB on/after 10/1/2015						14
15	N/A for FYB on/after 10/1/2015						15
16	Other						16
17	Total Statistical Basis	877,617	611,905			4,089,629	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	1.278586	1.530999			0.443637	18

KPMG LLP Compu-Max 2552-10

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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. 1-2, 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	10,252	3,455,336	337.04	7,718			2,601,275	1
2	Maintenance - Peritoneal Dialysis								2
3	Training - Hemodialysis								3
4	Training - Peritoneal Dialysis								4
5	Training - Continuous Ambulatory Peritoneal Dialysis	5	1,672	334.40	3			1,003	5
6	Training - Continuous Cycling Peritoneal Dialysis	82	27,647	337.16	34			11,463	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	41	95,691	2,333.93	14			32,675	9
10	Home Program - COntinuous Cycling Peritoneal Dialysis	917	2,163,167	2,358.96	617			1,455,478	10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	10,339	5,743,513		7,755			4,101,894	11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)	13,213							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	1,871,725			242.51			1
2	Maintenance - Peritoneal Dialysis							2
3	Training - Hemodialysis							3
4	Training - Peritoneal Dialysis							4
5	Training - Continuous Ambulatory Peritoneal Dialysis	931			310.33			5
6	Training - Continuous Cycling Peritoneal Dialysis	10,236			301.06			6
7	Home Program - Hemodialysis							7
8	Home Program - Peritoneal Dialysis							8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	10,001			714.36			9
10	Home Program - Continuous Cycling Peritoneal Dialysis	474,552			769.13			10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	2,367,445						11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)							12

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CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

WORKSHEET 1-5

DESCRIPTION				
1	Total expenses related to care of program beneficiaries (see instructions)		4,101,894	1
		1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	2,367,445	2,367,445	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)	2,367,445	2,367,445	2.03
2.04	Outlier payments	1		2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)	343	343	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)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	343	343	3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)	473,420	473,420	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)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	473,420	473,420	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)		473,763	8
9	Program payment (see instructions)		1,893,682	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)		5,743,513	12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)		5,743,513	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	1,181,939	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	68,680	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)	46.72	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0540	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1957	8
9	Sum of lines 7 and 8	0.2497	9
10	Allowable disproportionate share percentage (see instructions)	0.0519	10
11	Disproportionate share adjustment (see instructions)	61,343	11
12	Total prospective capital payments (see instructions)	1,311,962	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	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	Clinic						90
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 AND SPA CENTER							194.0
5								5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202