

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 05/23/2019 Time: 13:54
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BELOIT MEMORIAL HOSPITAL, INC. (52-0100) {(Provider Name(s) and Number(s))} for the cost reporting period beginning 01/01/2018 and ending 12/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		184,992	527,197		1,737,089	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		184,992	527,197		1,737,089	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,

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WORKSHEET S
PARTS I, II & III

search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

1	Street: 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)			
	0	1	2	3	4	5	V	XVIII	XIX	
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 HEALTH CARE	52-7075	27500		09 / 01 / 1996	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice	BELOIT REGIONAL HOSPICE	52-1525	27500		01 / 01 / 2017				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 / 2018	To: 12 / 31 / 2018		20
21	Type of control (see instructions)	2			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	723	296	77	34	2,017		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.	2						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.	2						27

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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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 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

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

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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PART I**

Title V and XIX Services	V	XIX	
90 Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94 Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95 If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96 Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97 If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

Rural Providers

	1	2	
105 Does this hospital qualify as a CAH?	N		105
106 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational	Speech
			Respiratory

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

Miscellaneous Cost Reporting Information

115 Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116 Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117 Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
	Premiums	Paid Losses	Self Insurance	
118.01 List amounts of malpractice premiums and paid losses:	377,198			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 care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125 Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126 If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	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)				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 / 2019	03 / 31 / 2019	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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			
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	04/30/2019	Y	04/30/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

	Y/N	Date	
Home Office Costs		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
42	Employer: BELOIT HEALTH SYSTEM INC		
43	Phone number: 6083645102	E-mail Address: AWIERSEMA@BELOITHEALTHSYSTEM.ORG	

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	91	33,215			6,998	557	14,298	1
2	HMO and other (see instructions)						2,308	2,424		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		91	33,215			6,998	557	14,298	7
8	Intensive Care Unit	31	12	4,380			926	34	2,106	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						132	816	13
14	Total (see instructions)		103	37,595			7,924	723	17,220	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					6,015	575	9,701	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116		26,659			23,741	624	26,659	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							48	998	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)								3	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)					1,820	184	4,352	1
2	HMO and other (see instructions)					510	877		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)		1,231.00			1,820	184	4,352	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)		38.00						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		1,287.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	97,177,395		97,177,395	2,677,808.00	36.29	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B		149,064		149,064	3,111.00	47.92	3
4	Physician-Part A - Administrative		413,345		413,345	2,051.00	201.53	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		22,700,387		22,700,387	118,319.00	191.86	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)		7,391,209		7,391,209	285,435.00	25.89	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,128,896		1,128,896	13,522.00	83.49	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)		31,615,199		31,615,199			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		3,847,655		3,847,655			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		51,021		51,021			21
22	Physician Part A - Administrative		61,509		61,509			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		3,374,738		3,374,738			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		9,953,928		9,953,928	379,148.00	26.25	27
28	Administrative & General under contract (see instructions)		255,850		255,850	1,644.00	155.63	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,899,318		1,899,318	69,517.00	27.32	30
31	Laundry & Linen Service		49,683		49,683	3,668.00	13.54	31
32	Housekeeping		1,396,128		1,396,128	104,503.00	13.36	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		938,324		938,324	57,097.00	16.43	34
35	Dietary under contract (see instructions)							35
36	Cafeteria		107,786		107,786	8,759.00	12.31	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,296,276		1,296,276	40,447.00	32.05	38
39	Central Services and Supply		571,207		571,207	27,925.00	20.46	39
40	Pharmacy		1,880,941		1,880,941	45,268.00	41.55	40
41	Medical Records & Medical Records Library		2,457,957		2,457,957	113,657.00	21.63	41
42	Social Service		531,235		531,235	16,911.00	31.41	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		74,583,794		74,583,794	2,558,022.00	29.16	1
2	Excluded area salaries (see instructions)		7,391,209		7,391,209	285,435.00	25.89	2
3	Subtotal salaries (line 1 minus line 2)		67,192,585		67,192,585	2,272,587.00	29.57	3
4	Subtotal other wages & related costs (see instructions)		1,128,896		1,128,896	13,522.00	83.49	4

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

5	Subtotal wage-related costs (see instructions)		31,676,708		31,676,708		47.14%	5
6	Total (sum of lines 3 through 5)		99,998,189		99,998,189	2,286,109.00	43.74	6
7	Total overhead cost (see instructions)		21,338,633		21,338,633	868,544.00	24.57	7

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	3,750,113	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	1,850,031	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)	25,250,575	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	542,849	10
11	Life Insurance (If employee is owner or beneficiary)	46,597	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	288,157	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	605,945	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	5,972,283	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	61,656	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	581,916	23
24	Total Wage Related cost (Sum of lines 1-23)	38,950,122	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

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3
PART V****Part V - Contract Labor and Benefit Cost****Hospital and Hospital-Based Component Identification:**

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**HHA CCN: 52-7075****WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: ROCK

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		1,465	139	760	2,364	1
2	Unduplicated Census Count (see instructions)		330.00				2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.00		1.00	4
5	Other Administrative Personnel	2.00		2.00	5
6	Direct Nursing Service	9.00		9.00	6
7	Nursing Supervisor				7
8	Physical Therapy Service	4.00		4.00	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.	3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	27500	20
20.01		40420	20.01
20.02		99952	20.02

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	2,431	443	108	63	3,045	21
22	Skilled Nursing Visit Charges	971,601	177,059	43,341	25,137	1,217,138	22
23	Physical Therapy Visits	1,747	115	35	44	1,941	23
24	Physical Therapy Visit Charges	763,439	50,255	15,295	19,228	848,217	24
25	Occupational Therapy Visits	554	56	13	8	631	25
26	Occupational Therapy Visit Charges	242,098	24,489	5,681	3,496	275,764	26
27	Speech Pathology Visits	41		3		44	27
28	Speech Pathology Visit Charges	17,917		1,311		19,228	28
29	Medical Social Service Visits	1				1	29
30	Medical Social Service Visit Charges	570				570	30
31	Home Health Aide Visits	296	151	2	15	464	31
32	Home Health Aide Visit Charges	56,240	28,690	380	2,850	88,160	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,070	765	161	130	6,126	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,051,865	280,493	66,008	50,711	2,449,077	35
36	Total Number of Episodes (standard/non-outlier)	366		54	10	430	36
37	Total Number of Ourlier Episodes		19		1	20	37
38	Total Non-Routine Medical Supply Charges	115,667	6,734	1,099		123,500	38

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	65					26	1
2	Number of times per week patient receives dialysis	3.00					7.00	2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day						4	4
5	Number of days in year dialysis furnished	312						5
6	Number of stations	18						6
7	Treatment capacity per day per station	7						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	5	11
12	Number of patients transplanted during the cost reporting period	7	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 I, line 18 and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)					23

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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HOSPITAL-BASED HOSPICE IDENTIFICATION DATA**HOSPICE CCN: 52-1525****WORKSHEET S-9
PARTS I THROUGH IV****PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015**

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days				
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
10	Hospice Continuous Home Care					10
11	Hospice Routine Home Care	24,823	624	1,212	26,659	11
12	Hospice Inpatient Respite Care					12
13	Hospice General Inpatient Care					13
14	Total Hospice Days	24,823	624	1,212	26,659	14

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
15	Hospice Inpatient Respite Care					15
16	Hospice General Inpatient Care					16

NOTE: Parts I and II, columns 1 and 2 also include the days reported in column 3 and 4.

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	0.232142	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	19,588,137	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	132,197,687	6
7	Medicaid cost (line 1 times line 6)	30,688,635	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.	11,100,498	8

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

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

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,100,498	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	20,920	7,484	28,404	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,856	7,484	12,340	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,856	7,484	12,340	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	15,479,125	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	624,039	27
27.0 1	Medicare allowable bad debts for the entire hospital complex (see instructions)	960,060	27.0 1
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	14,519,065	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,706,506	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,718,846	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,819,344	31

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		8,179,708	8,179,708	4,337,844	12,517,552	-878,977	11,638,575	1
2	00200	Cap Rel Costs-Mvble Equip		4,148,926	4,148,926	916,545	5,065,471		5,065,471	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		37,319,657	37,319,657		37,319,657	-12,120,322	25,199,335	4
5	00500	Administrative & General	9,953,928	21,368,548	31,322,476	-831,033	30,491,443	-7,999,905	22,491,538	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,899,318	6,001,445	7,900,763	-9,307	7,891,456	-714,249	7,177,207	7
8	00800	Laundry & Linen Service	49,683	649,464	699,147		699,147	-41,161	657,986	8
9	00900	Housekeeping	1,396,128	410,690	1,806,818	-515	1,806,303	-287,704	1,518,599	9
10	01000	Dietary	938,324	380,405	1,318,729		1,318,729	-7,401	1,311,328	10
11	01100	Cafeteria	107,786	556,516	664,302		664,302	-487,634	176,668	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,296,276	65,538	1,361,814		1,361,814	-525,525	836,289	13
14	01400	Central Services & Supply	571,207	603,440	1,174,647	-209,259	965,388		965,388	14
15	01500	Pharmacy	1,880,941	430,884	2,311,825		2,311,825		2,311,825	15
16	01600	Medical Records & Library	2,457,957	501,728	2,959,685		2,959,685	-620,055	2,339,630	16
17	01700	Social Service	531,235	10,659	541,894		541,894		541,894	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	7,438,903	270,841	7,709,744	-9,883	7,699,861	-114	7,699,747	30
31	03100	Intensive Care Unit	1,963,129	401,605	2,364,734	-1,598	2,363,136		2,363,136	31
43	04300	Nursery	188,661		188,661		188,661		188,661	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,907,677	1,432,057	3,339,734	-53,951	3,285,783		3,285,783	50
51	05100	Recovery Room	349,115	19,772	368,887		368,887		368,887	51
52	05200	Delivery Room & Labor Room	466,105		466,105		466,105		466,105	52
53	05300	Anesthesiology	149,064	198,962	348,026		348,026	-149,064	198,962	53
54	05400	Radiology-Diagnostic	1,422,260	669,167	2,091,427		2,091,427	-317,548	1,773,879	54
55	05500	Radiology-Therapeutic	408,801	561,047	969,848	-2,350	967,498		967,498	55
57	05700	CT Scan	850,710	524,047	1,374,757		1,374,757		1,374,757	57
58	05800	MRI	360,841	349,141	709,982	-33,144	676,838		676,838	58
59	05900	Cardiac Catheterization	1,661,495	672,171	2,333,666	-4,750	2,328,916		2,328,916	59
60	06000	Laboratory	3,151,858	5,357,453	8,509,311		8,509,311	-3,699	8,505,612	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	831,352	491,021	1,322,373	-2,710	1,319,663	-25,000	1,294,663	65
66	06600	Physical Therapy	2,422,141	223,266	2,645,407	-29,841	2,615,566	-1,329,916	1,285,650	66
67	06700	Occupational Therapy	254,013	32,219	286,232		286,232	-98,153	188,079	67
68	06800	Speech Pathology	145,368	32,526	177,894		177,894	-25,000	152,894	68
69	06900	Electrocardiology	284,440	45,801	330,241		330,241	-32,330	297,911	69
71	07100	Medical Supplies Charged to Patients		11,945,191	11,945,191		11,945,191	-1,182,950	10,762,241	71
73	07300	Drugs Charged to Patients		19,380,100	19,380,100		19,380,100	-4,409,154	14,970,946	73
74	07400	Renal Dialysis	1,427,988	2,123,525	3,551,513		3,551,513	-27	3,551,486	74
75	07500	ASC (Non-Distinct Part)	816,426	393,228	1,209,654	-200	1,209,454		1,209,454	75
76	03950	OTHER ANCILLARY								76
76.01	03280	SLEEP/EEG	248,850	187,896	436,746		436,746		436,746	76.01
76.02	03340	GI	729,330	234,331	963,661		963,661		963,661	76.02
76.03	03450	NUCLEAR MED	237,455	230,452	467,907		467,907		467,907	76.03
76.04	03550	PSYCH	1,860,547	524,204	2,384,751	-3,060	2,381,691	-522,313	1,859,378	76.04
76.05	03630	ULTRASOUND	467,600	119,883	587,483		587,483	-90,037	497,446	76.05
76.06	03650	VASCULAR LAB	549,377	82,912	632,289		632,289	-1,534	630,755	76.06
76.07	03951	MEDICAL OUTPATIENT	373,373	9,740	383,113		383,113		383,113	76.07
76.97	07697	CARDIAC REHABILITATION	217,266	4,586	221,852		221,852	-12	221,840	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY		341,500	341,500		341,500		341,500	76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	33,275,562	5,634,928	38,910,490		38,910,490	-38,910,490		90
91	09100	Emergency	4,243,696	830,710	5,074,406	-300	5,074,106	-325,060	4,749,046	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
101	10100	Home Health Agency	1,437,114	227,498	1,664,612		1,664,612	-1,680	1,662,932	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		3,940,109	3,940,109	-3,940,109				113
116	11600	Hospice	2,178,870	2,139,913	4,318,783	-98,365	4,220,418	-44,825	4,175,593	116
118		SUBTOTALS (sum of lines 1-117)	93,402,170	140,259,410	233,661,580	24,014	233,685,594	-71,151,839	162,533,755	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	55,425	70,539	125,964		125,964		125,964	190
194	07950	PATHOLOGY	20,041	32,574	52,615		52,615		52,615	194
194.0 1	07951	PHYSIATRY CLINIC	275,687	327	276,014		276,014		276,014	194.0 1
194.0 2	07952	JANESVILLE MED CENTER	149,194	67,058	216,252	-17,340	198,912		198,912	194.0 2
194.0 3	07955	OCCUPATIONAL HEALTH AND WELLNESS	1,480,059	192,445	1,672,504		1,672,504		1,672,504	194.0 3
194.0 4	07953	ASSISTED LIVING CENTERS	1,552,557	921,172	2,473,729	-6,060	2,467,669		2,467,669	194.0 4
194.0 5	07954	NORTHPOINTE FITNESS & SPA CENTER	242,262	2,036,311	2,278,573	-614	2,277,959		2,277,959	194.0 5
200		TOTAL (sum of lines 118-199)	97,177,395	143,579,836	240,757,231		240,757,231	-71,151,839	169,605,392	200

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		3,771,333
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Mvble Equip	2		168,776
500	Total reclassifications					3,940,109
	Code Letter - A					
1	RENTS & LEASES	B	Cap Rel Costs-Bldg & Fixt	1		566,511
2	RENTS & LEASES	B	Cap Rel Costs-Mvble Equip	2		747,769
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
500	Total reclassifications					1,314,280
	Code Letter - B					
	GRAND TOTAL (Increases)					5,254,389

(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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		3,771,333	11
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Interest Expense	113		168,776	11
500	Total reclassifications					3,940,109	500
	Code letter - A						
1	RENTS & LEASES	B	Administrative & General	5		831,033	10
2	RENTS & LEASES	B	Operation of Plant	7		9,307	10
3			Housekeeping	9		515	10
4			Central Services & Supply	14		209,259	10
5			Adults & Pediatrics	30		9,883	10
6			Intensive Care Unit	31		1,598	10
7			Operating Room	50		53,951	10
8			Radiology-Therapeutic	55		2,350	10
9			MRI	58		33,144	10
10			Cardiac Catheterization	59		4,750	10
11			Respiratory Therapy	65		2,710	10
12			Physical Therapy	66		29,841	10
13			ASC (Non-Distinct Part)	75		200	10
14			PSYCH	76.04		3,060	10
15			Emergency	91		300	10
16			Hospice	116		98,365	10
17			JANESVILLE MED CENTER	194.02		17,340	10
18			ASSISTED LIVING CENTERS	194.04		6,060	10
19			NORTHPOINTE FITNESS & SPA CEN	194.05		614	10
500	Total reclassifications					1,314,280	500
	Code letter - B						
	GRAND TOTAL (Decreases)					5,254,389	

(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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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**

		Acquisitions							
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	8,100,877					8,100,877		1
2	Land Improvements	6,573,316	1,126,556		1,126,556		7,699,872	3,611,645	2
3	Buildings and Fixtures	144,652,254	647,167		647,167	1,172,895	144,126,526	21,938,975	3
4	Building Improvements								4
5	Fixed Equipment	43,803,637	2,830,828		2,830,828	5,818,293	40,816,172	10,587,775	5
6	Movable Equipment	72,230,812	3,067,625		3,067,625	15,430,426	59,868,011	31,487,207	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	275,360,896	7,672,176		7,672,176	22,421,614	260,611,458	67,625,602	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	275,360,896	7,672,176		7,672,176	22,421,614	260,611,458	67,625,602	10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	8,179,708						8,179,708	1
2	Cap Rel Costs-Mvble Equip	4,148,926						4,148,926	2
3	Total (sum of lines 1-2)	12,328,634						12,328,634	3

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	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	200,743,447		200,743,447	0.770279					1
2	Cap Rel Costs-Mvble Equ	59,868,011		59,868,011	0.229721					2
3	Total (sum of lines 1-2)	260,611,458		260,611,458	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	7,300,731	566,511	3,771,333				11,638,575	1
2	Cap Rel Costs-Mvble Equip	4,148,926	747,769	168,776				5,065,471	2
3	Total (sum of lines 1-2)	11,449,657	1,314,280	3,940,109				16,704,046	3

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

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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
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	-60,339	Operation of Plant	7	8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-23,695,733			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 and allied health education (tuition, fees, books, etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	CRNA OFFSET	A	-58,031	Employee Benefits Department	4	33
34	CRNA OFFSET	A	-149,064	Anesthesiology	53	34
35	PATIENT PORTION OF OPERATORS TIME	A	-1,565	Employee Benefits Department	4	35
36	PATIENT PORTION OF OPERATORS TIME	A	-4,019	Administrative & General	5	36
37	ADVERTISING OFFSET	A	-674,471	Administrative & General	5	37
38	ADVERTISING OFFSET	A	-1,067	Dietary	10	38
39	ADVERTISING OFFSET	A	-83	Laboratory	60	39
40	ADVERTISING OFFSET	A	-6,463	Physical Therapy	66	40
41	ADVERTISING OFFSET	A	-27	Renal Dialysis	74	41
42	ADVERTISING OFFSET	A	-2,544	PSYCH	76.04	42
43	ADVERTISING OFFSET	A	-60	Emergency	91	43
44	ADVERTISING OFFSET	A	-1,016	Home Health Agency	101	44
45	ADVERTISING OFFSET	A	-44,825	Hospice	116	45
46	MISC REV OFFSET	B	-1,090,222	Administrative & General	5	46
47	MISC REV OFFSET	B	-1,540	Operation of Plant	7	47
48	MISC REV OFFSET	B	-7,415	Housekeeping	9	48
48.01	MISC REV OFFSET	B	-6,334	Dietary	10	48.01
48.02	MISC REV OFFSET	B	-487,634	Cafeteria	11	48.02
48.03	MISC REV OFFSET	B	-550	Nursing Administration	13	48.03
48.04	MISC REV OFFSET	B	-1,964	Medical Records & Library	16	48.04
48.05	MISC REV OFFSET	B	-114	Adults & Pediatrics	30	48.05
48.06	MISC REV OFFSET	B	-25,000	Respiratory Therapy	65	48.06
48.07	MISC REV OFFSET	B	-481	Physical Therapy	66	48.07
48.08	MISC REV OFFSET	B	-25,000	Speech Pathology	68	48.08
48.09	MISC REV OFFSET	B	-52,838	PSYCH	76.04	48.09

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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
48.10	MISC REV OFFSET	B	-1,534	VASCULAR LAB	76.06	48.10
48.11	MISC REV OFFSET	B	-12	CARDIAC REHABILITATION	76.97	48.11
48.12	MISC REV OFFSET	B	-664	Home Health Agency	101	48.12
49	REMOVE EST OF PHYS COSTS	A	-878,977	Cap Rel Costs-Bldg & Fixt	1	9
49.01	REMOVE EST OF PHYS COSTS	A	-12,060,726	Employee Benefits Department	4	49.01
49.02	REMOVE EST OF PHYS COSTS	A	-6,231,193	Administrative & General	5	49.02
49.03	REMOVE EST OF PHYS COSTS	A	-652,370	Operation of Plant	7	49.03
49.04	REMOVE EST OF PHYS COSTS	A	-41,161	Laundry & Linen Service	8	49.04
49.05	REMOVE EST OF PHYS COSTS	A	-280,289	Housekeeping	9	49.05
49.06	REMOVE EST OF PHYS COSTS	A	-524,975	Nursing Administration	13	49.06
49.07	REMOVE EST OF PHYS COSTS	A	-618,091	Medical Records & Library	16	49.07
49.08	REMOVE EST OF PHYS COSTS	A	-317,548	Radiology-Diagnostic	54	49.08
49.09	REMOVE EST OF PHYS COSTS	A	-3,616	Laboratory	60	49.09
49.10	REMOVE EST OF PHYS COSTS	A	-1,322,972	Physical Therapy	66	49.10
49.11	REMOVE EST OF PHYS COSTS	A	-98,153	Occupational Therapy	67	49.11
49.12	REMOVE EST OF PHYS COSTS	A	-32,330	Electrocardiology	69	49.12
49.13	REMOVE EST OF PHYS COSTS	A	-1,182,950	Medical Supplies Charged to Patients	71	49.13
49.14	REMOVE EST OF PHYS COSTS	A	-4,409,154	Drugs Charged to Patients	73	49.14
49.15	REMOVE EST OF PHYS COSTS	A	-90,037	ULTRASOUND	76.05	49.15
49.16	REMOVE EST OF PHYS COSTS	A	-16,006,688	Clinic	90	49.16
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-71,151,839			50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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.

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

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	2,940,996	2,854,394	86,602	179,000	651	56,024	2,801	1
2	90	Clinic INT MEDICINE	1,476,399	1,466,799	9,600	197,500	106	10,065	503	2
3	90	Clinic SURGERY	3,203,345	3,179,345	24,000	246,400	93	11,017	551	3
4	90	Clinic PEDIATRICS	1,068,897	1,068,897		169,700				4
5	90	Clinic OB/GYN	1,765,160	1,764,160	1,000	237,100	6	684	34	5
6	90	Clinic ALL OTHERS	12,658,935	12,366,792	292,143	211,500	1,195	121,511	6,076	6
7	91	Emergency ER PHYSICIANS	325,000	325,000		211,500				7
8	76.04	PSYCH PSYCH PHYSICIAN	466,931	466,931						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	23,905,663	23,492,318	413,345		2,051	199,301	9,965	200

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	90	Clinic FAMILY PRACTICE	43,460	1,280	22,370	659	57,963	28,639	2,883,033	1
2	90	Clinic INT MEDICINE	28,514	185	12,989	84	10,334		1,466,799	2
3	90	Clinic SURGERY	36,447	273	69,488	521	11,811	12,189	3,191,534	3
4	90	Clinic PEDIATRICS	11,745		10,173				1,068,897	4
5	90	Clinic OB/GYN	12,836	7	27,352	15	706	294	1,764,454	5
6	90	Clinic ALL OTHERS	126,547	2,920	234,826	5,419	129,850	162,293	12,529,085	6
7	91	Emergency ER PHYSICIANS							325,000	7
8	76.04	PSYCH PSYCH PHYSICIAN							466,931	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	259,549	4,665	377,198	6,698	210,664	203,415	23,695,733	200

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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 DEPARTMEN T	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	11,638,575	11,638,575					1
2	Cap Rel Costs-Mvble Equip	5,065,471		5,065,471				2
4	Employee Benefits Department	25,199,335			25,199,335			4
5	Administrative & General	22,491,538	3,140,064	866,938	3,925,300	30,423,840	30,423,840	5
6	Maintenance & Repairs							6
7	Operation of Plant	7,177,207	612,806	52,631	748,985	8,591,629	1,878,053	7
8	Laundry & Linen Service	657,986	29,175		19,592	706,753	154,490	8
9	Housekeeping	1,518,599	8,542	1,783	550,555	2,079,479	454,555	9
10	Dietary	1,311,328	87,525	5,337	370,022	1,774,212	387,827	10
11	Cafeteria	176,668	81,179	2,432	42,505	302,784	66,186	11
12	Maintenance of Personnel							12
13	Nursing Administration	836,289	33,944	136,486	511,179	1,517,898	331,799	13
14	Central Services & Supply	965,388	150,061	286,170	225,252	1,626,871	355,619	14
15	Pharmacy	2,311,825	49,789	167,957	741,738	3,271,309	715,079	15
16	Medical Records & Library	2,339,630	191,458	111	969,281	3,500,480	765,173	16
17	Social Service	541,894	9,293		209,489	760,676	166,277	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	7,699,747	790,089	96,257	2,933,487	11,519,580	2,518,077	30
31	Intensive Care Unit	2,363,136	67,493	119,550	774,148	3,324,327	726,668	31
43	Nursery	188,661			74,397	263,058	57,502	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,285,783	219,713	336,681	752,281	4,594,458	1,004,307	50
51	Recovery Room	368,887	23,993		137,671	530,551	115,974	51
52	Delivery Room & Labor Room	466,105			183,806	649,911	142,065	52
53	Anesthesiology	198,962	9,105	16,819	58,782	283,668	62,007	53
54	Radiology-Diagnostic	1,773,879	259,402	152,435	560,860	2,746,576	600,377	54
55	Radiology-Therapeutic	967,498	127,401	74,924	161,208	1,331,031	290,951	55
57	CT Scan	1,374,757	24,932	131,730	335,472	1,866,891	408,086	57
58	MRI	676,838	17,798	125,899	142,295	962,830	210,466	58
59	Cardiac Catheterization	2,328,916	75,528	668,588	655,201	3,728,233	814,958	59
60	Laboratory	8,505,612	280,072	197,246	1,242,916	10,225,846	2,235,278	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,294,663	46,748	57,501	327,839	1,726,751	377,452	65
66	Physical Therapy	1,285,650	296,387	39,710	955,157	2,576,904	563,288	66
67	Occupational Therapy	188,079	14,944		100,169	303,192	66,275	67
68	Speech Pathology	152,894	8,542	186	57,325	218,947	47,860	68
69	Electrocardiology	297,911	9,199	10,422	112,167	429,699	93,928	69
71	Medical Supplies Charged to Patients	10,762,241				10,762,241	2,352,529	71
73	Drugs Charged to Patients	14,970,946				14,970,946	3,272,518	73
74	Renal Dialysis	3,551,486	132,489	29,046	563,118	4,276,139	934,726	74
75	ASC (Non-Distinct Part)	1,209,454	728,698	511,157	321,953	2,771,262	605,773	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	436,746	12,691	10,082	98,133	557,652	121,898	76.01
76.02	GI	963,661	57,956	231,430	287,607	1,540,654	336,773	76.02
76.03	NUCLEAR MED	467,907	14,663	7,652	93,639	583,861	127,627	76.03
76.04	PSYCH	1,859,378	118,052	1,705	733,696	2,712,831	593,000	76.04
76.05	ULTRASOUND	497,446	29,231	85,684	184,395	796,756	174,164	76.05
76.06	VASCULAR LAB	630,755	37,473	74,289	216,644	959,161	209,664	76.06
76.07	MEDICAL OUTPATIENT	383,113	18,774	521	147,237	549,645	120,147	76.07
76.97	CARDIAC REHABILITATION	221,840	31,597		85,678	339,115	74,127	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	341,500				341,500	74,649	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	4,749,046	494,041	452,258	1,673,476	7,368,821	1,610,758	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,662,932	63,006	8,522	566,717	2,301,177	503,017	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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 DEPARTMEN T	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
116	Hospice	4,175,593	75,096	30,410	859,224	5,140,323	1,123,628	116
118	SUBTOTALS (sum of lines 1-117)	162,533,755	8,478,949	4,990,549	23,710,596	157,810,468	27,845,575	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	125,964	22,003	5,865	21,857	175,689	38,404	190
194	PATHOLOGY	52,615	9,744	7,664	7,903	77,926	17,034	194
194.0 1	PHYSIATRY CLINIC	276,014	12,654		108,716	397,384	86,865	194.0 1
194.0 2	JANESVILLE MED CENTER	198,912	94,377	3,974	58,834	356,097	77,840	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	1,672,504	163,842	520	583,652	2,420,518	529,103	194.0 3
194.0 4	ASSISTED LIVING CENTERS	2,467,669	1,786,976	18,021	612,242	4,884,908	1,067,797	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	2,277,959	1,070,030	38,878	95,535	3,482,402	761,222	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	169,605,392	11,638,575	5,065,471	25,199,335	169,605,392	30,423,840	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	10,469,682						7
8	Laundry & Linen Service	38,735	899,978					8
9	Housekeeping	11,341		2,545,375				9
10	Dietary	116,205		28,387	2,306,631			10
11	Cafeteria	107,780		26,329		503,079		11
12	Maintenance of Personnel							12
13	Nursing Administration	45,066		11,009		14,819	1,920,591	13
14	Central Services & Supply	199,233		48,670		10,140		14
15	Pharmacy	66,104		16,148		17,159		15
16	Medical Records & Library	254,195		62,097		42,898		16
17	Social Service	12,338		3,014		6,240		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	1,048,985	399,608	256,253	2,017,203	96,714	748,909	30
31	Intensive Care Unit	89,609	50,381	21,890	289,428	21,839	169,109	31
43	Nursery					2,340	18,119	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	291,709	131,409	71,261		21,059	163,069	50
51	Recovery Room	31,855		7,782		3,120	24,158	51
52	Delivery Room & Labor Room					4,680	36,238	52
53	Anesthesiology	12,089		2,953		1,560	12,079	53
54	Radiology-Diagnostic	344,402	74,749	84,133		18,719		54
55	Radiology-Therapeutic	169,148		41,321		3,900		55
57	CT Scan	33,102		8,086		8,580		57
58	MRI	23,630		5,772		3,120		58
59	Cardiac Catheterization	100,277		24,496		15,599		59
60	Laboratory	371,846		90,837		46,798		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	62,066		15,162		10,140		65
66	Physical Therapy	393,506	20,631	96,129		24,179		66
67	Occupational Therapy	19,841		4,847		2,340		67
68	Speech Pathology	11,341		2,771		1,560		68
69	Electrocardiology	12,214		2,984		4,680		69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	175,903	33,338	42,971		18,719	144,950	74
75	ASC (Non-Distinct Part)	967,477	27,956	236,342		9,360	72,475	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	16,850		4,116		3,120	24,158	76.01
76.02	GI	76,946		18,797		10,140	78,515	76.02
76.03	NUCLEAR MED	19,467		4,756		2,340		76.03
76.04	PSYCH	156,735		38,288		17,159		76.04
76.05	ULTRASOUND	38,810		9,481		4,680		76.05
76.06	VASCULAR LAB	49,752	10,764	12,154		4,680	36,238	76.06
76.07	MEDICAL OUTPATIENT	24,926		6,089		3,900	30,198	76.07
76.97	CARDIAC REHABILITATION	41,950		10,248		2,340	18,119	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	655,927	151,142	160,234		44,458	344,257	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	83,652		20,435				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	99,704		24,356				116
118	SUBTOTALS (sum of lines 1-117)	6,274,716	899,978	1,520,598	2,306,631	503,079	1,920,591	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	29,213		7,136				190
194	PATHOLOGY	12,937		3,160				194
194.0 1	PHYSIATRY CLINIC	16,800		4,104				194.0 1
194.0 2	JANESVILLE MED CENTER	125,303		30,610				194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	217,529		53,140				194.0 3
194.0 4	ASSISTED LIVING CENTERS	2,372,528		579,579				194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	1,420,656		347,048				194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,469,682	899,978	2,545,375	2,306,631	503,079	1,920,591	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	2,240,533						14
15	Pharmacy	12,239	4,098,038					15
16	Medical Records & Library	32		4,624,875				16
17	Social Service				948,545			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	87,758	1,072	175,896	948,545	19,818,600		30
31	Intensive Care Unit	24,596		70,185		4,788,032		31
43	Nursery			10,369		351,388		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,118,223	19,307	222,089		7,636,891		50
51	Recovery Room	10,300	272	37,009		761,021		51
52	Delivery Room & Labor Room			28,973		861,867		52
53	Anesthesiology	30,780	23,139	41,251		469,526		53
54	Radiology-Diagnostic	8,392	1,587	122,557		4,001,492		54
55	Radiology-Therapeutic	2,938		64,912		1,904,201		55
57	CT Scan	6,239	1,103	362,753		2,694,840		57
58	MRI	477	471	134,800		1,341,566		58
59	Cardiac Catheterization	255,328	14,259	147,578		5,100,728		59
60	Laboratory	19,130	332	662,602		13,652,669		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,340		42,108		2,249,019		65
66	Physical Therapy	42,238	132	90,832		3,807,839		66
67	Occupational Therapy	77		12,281		408,853		67
68	Speech Pathology	2,190	4	5,413		290,086		68
69	Electrocardiology	2,462		113,271		659,238		69
71	Medical Supplies Charged to Patients	25,327		754,957		13,895,054		71
73	Drugs Charged to Patients		3,695,350	627,448		22,566,262		73
74	Renal Dialysis	172,388	239,598	122,297		6,161,029		74
75	ASC (Non-Distinct Part)	206,570	1,747	49,000		4,947,962		75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	14		15,697		743,505		76.01
76.02	GI	91,706	2,244	142,854		2,298,629		76.02
76.03	NUCLEAR MED	81	79,563	67,687		885,382		76.03
76.04	PSYCH	128		23,924		3,542,065		76.04
76.05	ULTRASOUND	4,597	402	60,179		1,089,069		76.05
76.06	VASCULAR LAB	622		39,702		1,322,737		76.06
76.07	MEDICAL OUTPATIENT	5,492	75	6,029		746,501		76.07
76.97	CARDIAC REHABILITATION	382		9,749		496,030		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	14		26,396		442,559		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	85,069	851	284,936		10,706,453		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	6,910	3,236	14,245		2,932,672		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	1,386	60	34,896		6,424,353		116
118	SUBTOTALS (sum of lines 1-117)	2,239,425	4,084,804	4,624,875	948,545	149,998,118		118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					250,442		190
194	PATHOLOGY	28				111,085		194
194.0 1	PHYSIATRY CLINIC		15			505,168		194.0 1
194.0 2	JANESVILLE MED CENTER	49	1,183			591,082		194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	522	11,897			3,232,709		194.0 3
194.0 4	ASSISTED LIVING CENTERS	509	139			8,905,460		194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER					6,011,328		194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,240,533	4,098,038	4,624,875	948,545	169,605,392		202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	19,818,600						30
31	Intensive Care Unit	4,788,032						31
43	Nursery	351,388						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,636,891						50
51	Recovery Room	761,021						51
52	Delivery Room & Labor Room	861,867						52
53	Anesthesiology	469,526						53
54	Radiology-Diagnostic	4,001,492						54
55	Radiology-Therapeutic	1,904,201						55
57	CT Scan	2,694,840						57
58	MRI	1,341,566						58
59	Cardiac Catheterization	5,100,728						59
60	Laboratory	13,652,669						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,249,019						65
66	Physical Therapy	3,807,839						66
67	Occupational Therapy	408,853						67
68	Speech Pathology	290,086						68
69	Electrocardiology	659,238						69
71	Medical Supplies Charged to Patients	13,895,054						71
73	Drugs Charged to Patients	22,566,262						73
74	Renal Dialysis	6,161,029						74
75	ASC (Non-Distinct Part)	4,947,962						75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	743,505						76.01
76.02	GI	2,298,629						76.02
76.03	NUCLEAR MED	885,382						76.03
76.04	PSYCH	3,542,065						76.04
76.05	ULTRASOUND	1,089,069						76.05
76.06	VASCULAR LAB	1,322,737						76.06
76.07	MEDICAL OUTPATIENT	746,501						76.07
76.97	CARDIAC REHABILITATION	496,030						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	442,559						76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	10,706,453						91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,932,672						101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	6,424,353						116
118	SUBTOTALS (sum of lines 1-117)	149,998,118						118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	250,442						190
194	PATHOLOGY	111,085						194
194.0 1	PHYSIATRY CLINIC	505,168						194.0 1
194.0 2	JANESVILLE MED CENTER	591,082						194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	3,232,709						194.0 3
194.0 4	ASSISTED LIVING CENTERS	8,905,460						194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	6,011,328						194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	169,605,392						202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		3,140,064	866,938	4,007,002	4,007,002		5
6	Maintenance & Repairs							6
7	Operation of Plant		612,806	52,631	665,437	247,353	912,790	7
8	Laundry & Linen Service		29,175		29,175	20,347	3,377	8
9	Housekeeping		8,542	1,783	10,325	59,868	989	9
10	Dietary		87,525	5,337	92,862	51,080	10,131	10
11	Cafeteria		81,179	2,432	83,611	8,717	9,397	11
12	Maintenance of Personnel							12
13	Nursing Administration		33,944	136,486	170,430	43,700	3,929	13
14	Central Services & Supply		150,061	286,170	436,231	46,838	17,370	14
15	Pharmacy		49,789	167,957	217,746	94,181	5,763	15
16	Medical Records & Library		191,458	111	191,569	100,779	22,162	16
17	Social Service		9,293		9,293	21,900	1,076	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		790,089	96,257	886,346	331,649	91,455	30
31	Intensive Care Unit		67,493	119,550	187,043	95,707	7,812	31
43	Nursery					7,573		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		219,713	336,681	556,394	132,274	25,432	50
51	Recovery Room		23,993		23,993	15,275	2,777	51
52	Delivery Room & Labor Room					18,711		52
53	Anesthesiology		9,105	16,819	25,924	8,167	1,054	53
54	Radiology-Diagnostic		259,402	152,435	411,837	79,074	30,026	54
55	Radiology-Therapeutic		127,401	74,924	202,325	38,320	14,747	55
57	CT Scan		24,932	131,730	156,662	53,748	2,886	57
58	MRI		17,798	125,899	143,697	27,720	2,060	58
59	Cardiac Catheterization		75,528	668,588	744,116	107,336	8,743	59
60	Laboratory		280,072	197,246	477,318	294,402	32,419	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		46,748	57,501	104,249	49,713	5,411	65
66	Physical Therapy		296,387	39,710	336,097	74,189	34,308	66
67	Occupational Therapy		14,944		14,944	8,729	1,730	67
68	Speech Pathology		8,542	186	8,728	6,303	989	68
69	Electrocardiology		9,199	10,422	19,621	12,371	1,065	69
71	Medical Supplies Charged to Patients					309,845		71
73	Drugs Charged to Patients					430,980		73
74	Renal Dialysis		132,489	29,046	161,535	123,110	15,336	74
75	ASC (Non-Distinct Part)		728,698	511,157	1,239,855	79,785	84,349	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		12,691	10,082	22,773	16,055	1,469	76.01
76.02	GI		57,956	231,430	289,386	44,355	6,709	76.02
76.03	NUCLEAR MED		14,663	7,652	22,315	16,809	1,697	76.03
76.04	PSYCH		118,052	1,705	119,757	78,102	13,665	76.04
76.05	ULTRASOUND		29,231	85,684	114,915	22,939	3,384	76.05
76.06	VASCULAR LAB		37,473	74,289	111,762	27,614	4,338	76.06
76.07	MEDICAL OUTPATIENT		18,774	521	19,295	15,824	2,173	76.07
76.97	CARDIAC REHABILITATION		31,597		31,597	9,763	3,657	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					9,832		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		494,041	452,258	946,299	212,148	57,186	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		63,006	8,522	71,528	66,251	7,293	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		75,096	30,410	105,506	147,990	8,693	116
118	SUBTOTALS (sum of lines 1-117)		8,478,949	4,990,549	13,469,498	3,667,426	547,057	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		22,003	5,865	27,868	5,058	2,547	190
194	PATHOLOGY		9,744	7,664	17,408	2,243	1,128	194
194.0 1	PHYSIATRY CLINIC		12,654		12,654	11,441	1,465	194.0 1
194.0 2	JANESVILLE MED CENTER		94,377	3,974	98,351	10,252	10,924	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS		163,842	520	164,362	69,687	18,965	194.0 3
194.0 4	ASSISTED LIVING CENTERS		1,786,976	18,021	1,804,997	140,637	206,845	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		1,070,030	38,878	1,108,908	100,258	123,859	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		11,638,575	5,065,471	16,704,046	4,007,002	912,790	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	52,899						8
9	Housekeeping		71,182					9
10	Dietary		794	154,867				10
11	Cafeteria		736		102,461			11
12	Maintenance of Personnel							12
13	Nursing Administration		308		3,018	221,385		13
14	Central Services & Supply		1,361		2,065		503,865	14
15	Pharmacy		452		3,495		2,752	15
16	Medical Records & Library		1,737		8,737		7	16
17	Social Service		84		1,271			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	23,487	7,166	135,435	19,698	86,326	19,735	30
31	Intensive Care Unit	2,961	612	19,432	4,448	19,493	5,531	31
43	Nursery				477	2,089		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,724	1,993		4,289	18,797	251,475	50
51	Recovery Room		218		635	2,785	2,316	51
52	Delivery Room & Labor Room				953	4,177		52
53	Anesthesiology		83		318	1,392	6,922	53
54	Radiology-Diagnostic	4,394	2,353		3,813		1,887	54
55	Radiology-Therapeutic		1,156		794		661	55
57	CT Scan		226		1,747		1,403	57
58	MRI		161		635		107	58
59	Cardiac Catheterization		685		3,177		57,420	59
60	Laboratory		2,540		9,531		4,302	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		424		2,065		3,450	65
66	Physical Therapy	1,213	2,688		4,924		9,499	66
67	Occupational Therapy		136		477		17	67
68	Speech Pathology		77		318		492	68
69	Electrocardiology		83		953		554	69
71	Medical Supplies Charged to Patients						5,696	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,960	1,202		3,813	16,708	38,768	74
75	ASC (Non-Distinct Part)	1,643	6,609		1,906	8,354	46,455	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		115		635	2,785	3	76.01
76.02	GI		526		2,065	9,050	20,623	76.02
76.03	NUCLEAR MED		133		477		18	76.03
76.04	PSYCH		1,071		3,495		29	76.04
76.05	ULTRASOUND		265		953		1,034	76.05
76.06	VASCULAR LAB	633	340		953	4,177	140	76.06
76.07	MEDICAL OUTPATIENT		170		794	3,481	1,235	76.07
76.97	CARDIAC REHABILITATION		287		477	2,089	86	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY						3	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,884	4,481		9,055	39,682	19,131	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		571				1,554	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		681				312	116
118	SUBTOTALS (sum of lines 1-117)	52,899	42,524	154,867	102,461	221,385	503,617	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		200					190
194	PATHOLOGY		88				6	194
194.0 1	PHYSIATRY CLINIC		115					194.0 1
194.0 2	JANESVILLE MED CENTER		856				11	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS		1,486				117	194.0 3
194.0 4	ASSISTED LIVING CENTERS		16,208				114	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		9,705					194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	52,899	71,182	154,867	102,461	221,385	503,865	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	324,389						15
16	Medical Records & Library		324,991					16
17	Social Service			33,624				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	85	12,360	33,624	1,647,366		1,647,366	30
31	Intensive Care Unit		4,932		347,971		347,971	31
43	Nursery		729		10,868		10,868	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,528	15,606		1,015,512		1,015,512	50
51	Recovery Room	22	2,601		50,622		50,622	51
52	Delivery Room & Labor Room		2,036		25,877		25,877	52
53	Anesthesiology	1,832	2,899		48,591		48,591	53
54	Radiology-Diagnostic	126	8,612		542,122		542,122	54
55	Radiology-Therapeutic		4,561		262,564		262,564	55
57	CT Scan	87	25,491		242,250		242,250	57
58	MRI	37	9,473		183,890		183,890	58
59	Cardiac Catheterization	1,129	10,370		932,976		932,976	59
60	Laboratory	26	46,562		867,100		867,100	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,959		168,271		168,271	65
66	Physical Therapy	10	6,383		469,311		469,311	66
67	Occupational Therapy		863		26,896		26,896	67
68	Speech Pathology		380		17,287		17,287	68
69	Electrocardiology		7,960		42,607		42,607	69
71	Medical Supplies Charged to Patients		53,048		368,589		368,589	71
73	Drugs Charged to Patients	292,513	44,091		767,584		767,584	73
74	Renal Dialysis	18,966	8,594		389,992		389,992	74
75	ASC (Non-Distinct Part)	138	3,443		1,472,537		1,472,537	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		1,103		44,938		44,938	76.01
76.02	GI	178	10,039		382,931		382,931	76.02
76.03	NUCLEAR MED	6,298	4,756		52,503		52,503	76.03
76.04	PSYCH		1,681		217,800		217,800	76.04
76.05	ULTRASOUND	32	4,229		147,751		147,751	76.05
76.06	VASCULAR LAB		2,790		152,747		152,747	76.06
76.07	MEDICAL OUTPATIENT	6	424		43,402		43,402	76.07
76.97	CARDIAC REHABILITATION		685		48,641		48,641	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		1,855		11,690		11,690	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	67	20,023		1,316,956		1,316,956	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	256	1,001		148,454		148,454	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	5	2,452		265,639		265,639	116
118	SUBTOTALS (sum of lines 1-117)	323,341	324,991	33,624	12,734,235		12,734,235	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				35,673		35,673	190
194	PATHOLOGY				20,873		20,873	194
194.0 1	PHYSIATRY CLINIC	1			25,676		25,676	194.0 1
194.0 2	JANESVILLE MED CENTER	94			120,488		120,488	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	942			255,559		255,559	194.0 3
194.0 4	ASSISTED LIVING CENTERS	11			2,168,812		2,168,812	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER				1,342,730		1,342,730	194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	324,389	324,991	33,624	16,704,046		16,704,046	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	619,927						1
2	Cap Rel Costs-Mvble Equip		4,704,224					2
4	Employee Benefits Department			63,901,833				4
5	Administrative & General	167,255	805,113	9,953,928	-30,423,840	139,181,552		5
6	Maintenance & Repairs							6
7	Operation of Plant	32,641	48,878	1,899,318		8,591,629	420,031	7
8	Laundry & Linen Service	1,554		49,683		706,753	1,554	8
9	Housekeeping	455	1,656	1,396,128		2,079,479	455	9
10	Dietary	4,662	4,956	938,324		1,774,212	4,662	10
11	Cafeteria	4,324	2,259	107,786		302,784	4,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,808	126,752	1,296,276		1,517,898	1,808	13
14	Central Services & Supply	7,993	265,762	571,207		1,626,871	7,993	14
15	Pharmacy	2,652	155,979	1,880,941		3,271,309	2,652	15
16	Medical Records & Library	10,198	103	2,457,957		3,500,480	10,198	16
17	Social Service	495		531,235		760,676	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	89,392	7,438,903		11,519,580	42,084	30
31	Intensive Care Unit	3,595	111,024	1,963,129		3,324,327	3,595	31
43	Nurserv			188,661		263,058		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,703	312,670	1,907,677		4,594,458	11,703	50
51	Recovery Room	1,278		349,115		530,551	1,278	51
52	Delivery Room & Labor Room			466,105		649,911		52
53	Anesthesiology	485	15,620	149,064		283,668	485	53
54	Radiology-Diagnostic	13,817	141,564	1,422,260		2,746,576	13,817	54
55	Radiology-Therapeutic	6,786	69,581	408,801		1,331,031	6,786	55
57	CT Scan	1,328	122,336	850,710		1,866,891	1,328	57
58	MRI	948	116,920	360,841		962,830	948	58
59	Cardiac Catheterization	4,023	620,907	1,661,495		3,728,233	4,023	59
60	Laboratory	14,918	183,179	3,151,858		10,225,846	14,918	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,490	53,400	831,352		1,726,751	2,490	65
66	Physical Therapy	15,787	36,878	2,422,141		2,576,904	15,787	66
67	Occupational Therapy	796		254,013		303,192	796	67
68	Speech Pathology	455	173	145,368		218,947	455	68
69	Electrocardiology	490	9,679	284,440		429,699	490	69
71	Medical Supplies Charged to Patients					10,762,241		71
73	Drugs Charged to Patients					14,970,946		73
74	Renal Dialysis	7,057	26,975	1,427,988		4,276,139	7,057	74
75	ASC (Non-Distinct Part)	38,814	474,704	816,426		2,771,262	38,814	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	676	9,363	248,850		557,652	676	76.01
76.02	GI	3,087	214,925	729,330		1,540,654	3,087	76.02
76.03	NUCLEAR MED	781	7,106	237,455		583,861	781	76.03
76.04	PSYCH	6,288	1,583	1,860,547		2,712,831	6,288	76.04
76.05	ULTRASOUND	1,557	79,573	467,600		796,756	1,557	76.05
76.06	VASCULAR LAB	1,996	68,991	549,377		959,161	1,996	76.06
76.07	MEDICAL OUTPATIENT	1,000	484	373,373		549,645	1,000	76.07
76.97	CARDIAC REHABILITATION	1,683		217,266		339,115	1,683	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY					341,500		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	26,315	420,005	4,243,696		7,368,821	26,315	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,356	7,914	1,437,114		2,301,177	3,356	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	4,000	28,241	2,178,870		5,140,323	4,000	116

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	
118	SUBTOTALS (sum of lines 1-117)	451,630	4,634,645	60,126,608	-30,423,840	127,386,628	251,734	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,172	5,447	55,425		175,689	1,172	190
194	PATHOLOGY	519	7,117	20,041		77,926	519	194
194.0 1	PHYSIATRY CLINIC	674		275,687		397,384	674	194.0 1
194.0 2	JANESVILLE MED CENTER	5,027	3,691	149,194		356,097	5,027	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	8,727	483	1,480,059		2,420,518	8,727	194.0 3
194.0 4	ASSISTED LIVING CENTERS	95,183	16,736	1,552,557		4,884,908	95,183	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER	56,995	36,105	242,262		3,482,402	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)	11,638,575	5,065,471	25,199,335		30,423,840	10,469,682	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.774106	1.076792	0.394344		0.218591	24.925975	203
204	Cost to be allocated (Per Wkst. B, Part II)					4,007,002	912,790	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.028790	2.173149	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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 ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	602,000						8
9	Housekeeping		418,022					9
10	Dietary		4,662	16,784				10
11	Cafeteria		4,324		645			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,808		19	318		13
14	Central Services & Supply		7,993		13		10,249,057	14
15	Pharmacy		2,652		22		55,988	15
16	Medical Records & Library		10,198		55		145	16
17	Social Service		495		8		1	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	267,300	42,084	14,678	124	124	401,437	30
31	Intensive Care Unit	33,700	3,595	2,106	28	28	112,513	31
43	Nursery				3	3		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	87,900	11,703		27	27	5,115,194	50
51	Recovery Room		1,278		4	4	47,114	51
52	Delivery Room & Labor Room				6	6		52
53	Anesthesiology		485		2	2	140,799	53
54	Radiology-Diagnostic	50,000	13,817		24		38,387	54
55	Radiology-Therapeutic		6,786		5		13,438	55
57	CT Scan		1,328		11		28,538	57
58	MRI		948		4		2,182	58
59	Cardiac Catheterization		4,023		20		1,167,966	59
60	Laboratory		14,918		60		87,510	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,490		13		70,172	65
66	Physical Therapy	13,800	15,787		31		193,214	66
67	Occupational Therapy		796		3		354	67
68	Speech Pathology		455		2		10,017	68
69	Electrocardiology		490		6		11,263	69
71	Medical Supplies Charged to Patients						115,853	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	22,300	7,057		24	24	788,569	74
75	ASC (Non-Distinct Part)	18,700	38,814		12	12	944,928	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		676		4	4	63	76.01
76.02	GI		3,087		13	13	419,498	76.02
76.03	NUCLEAR MED		781		3		369	76.03
76.04	PSYCH		6,288		22		587	76.04
76.05	ULTRASOUND		1,557		6		21,027	76.05
76.06	VASCULAR LAB	7,200	1,996		6	6	2,847	76.06
76.07	MEDICAL OUTPATIENT		1,000		5	5	25,121	76.07
76.97	CARDIAC REHABILITATION		1,683		3	3	1,746	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY						63	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	101,100	26,315		57	57	389,137	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		3,356				31,607	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice		4,000				6,341	116
118	SUBTOTALS (sum of lines 1-117)	602,000	249,725	16,784	645	318	10,243,988	118

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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 ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,172					190
194	PATHOLOGY		519				128	194
194.0 1	PHYSIATRY CLINIC		674					194.0 1
194.0 2	JANESVILLE MED CENTER		5,027				225	194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS		8,727				2,389	194.0 3
194.0 4	ASSISTED LIVING CENTERS		95,183				2,327	194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER		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)	899,978	2,545,375	2,306,631	503,079	1,920,591	2,240,533	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.494980	6.089093	137.430350	779.967442	6,039.594340	0.218609	203
204	Cost to be allocated (Per Wkst. B, Part II)	52,899	71,182	154,867	102,461	221,385	503,865	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.087872	0.170283	9.227061	158.854264	696.179245	0.049162	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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				
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	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	15,960,393						15
16	Medical Records & Library		646,148,910					16
17	Social Service			100				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	4,177	24,573,342	100				30
31	Intensive Care Unit		9,805,104					31
43	Nursery		1,448,593					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	75,192	31,026,623					50
51	Recovery Room	1,061	5,170,357					51
52	Delivery Room & Labor Room		4,047,611					52
53	Anesthesiology	90,117	5,762,919					53
54	Radiology-Diagnostic	6,179	17,121,656					54
55	Radiology-Therapeutic		9,068,495					55
57	CT Scan	4,294	50,677,989					57
58	MRI	1,834	18,832,131					58
59	Cardiac Catheterization	55,532	20,617,190					59
60	Laboratory	1,293	92,567,973					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,882,630					65
66	Physical Therapy	516	12,689,552					66
67	Occupational Therapy		1,715,728					67
68	Speech Pathology	15	756,166					68
69	Electrocardiology		15,824,346					69
71	Medical Supplies Charged to Patients		105,506,956					71
73	Drugs Charged to Patients	14,392,064	87,656,875					73
74	Renal Dialysis	933,150	17,085,351					74
75	ASC (Non-Distinct Part)	6,803	6,845,434					75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		2,192,883					76.01
76.02	GI	8,741	19,957,272					76.02
76.03	NUCLEAR MED	309,868	9,456,074					76.03
76.04	PSYCH		3,342,210					76.04
76.05	ULTRASOUND	1,567	8,407,297					76.05
76.06	VASCULAR LAB		5,546,514					76.06
76.07	MEDICAL OUTPATIENT	292	842,217					76.07
76.97	CARDIAC REHABILITATION		1,361,956					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		3,687,620					76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	3,316	39,806,586					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	12,605	1,990,095					101
	SPECIAL PURPOSE COST CENTERS							

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT				
		15	16	17				
116	Hospice	232	4,875,165					116
118	SUBTOTALS (sum of lines 1-117)	15,908,848	646,148,910	100				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.0 1	PHYSIATRY CLINIC	59						194.0 1
194.0 2	JANESVILLE MED CENTER	4,609						194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS	46,336						194.0 3
194.0 4	ASSISTED LIVING CENTERS	541						194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER							194.0 5
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,098,038	4,624,875	948,545				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.256763	0.007158	9,485.450000				203
204	Cost to be allocated (Per Wkst. B, Part II)	324,389	324,991	33,624				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.020325	0.000503	336.240000				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	19,818,600		19,818,600		19,818,600	30
31	Intensive Care Unit	4,788,032		4,788,032		4,788,032	31
43	Nursery	351,388		351,388		351,388	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,636,891		7,636,891		7,636,891	50
51	Recovery Room	761,021		761,021		761,021	51
52	Delivery Room & Labor Room	861,867		861,867		861,867	52
53	Anesthesiology	469,526		469,526		469,526	53
54	Radiology-Diagnostic	4,001,492		4,001,492		4,001,492	54
55	Radiology-Therapeutic	1,904,201		1,904,201		1,904,201	55
57	CT Scan	2,694,840		2,694,840		2,694,840	57
58	MRI	1,341,566		1,341,566		1,341,566	58
59	Cardiac Catheterization	5,100,728		5,100,728		5,100,728	59
60	Laboratory	13,652,669		13,652,669		13,652,669	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,249,019		2,249,019		2,249,019	65
66	Physical Therapy	3,807,839		3,807,839		3,807,839	66
67	Occupational Therapy	408,853		408,853		408,853	67
68	Speech Pathology	290,086		290,086		290,086	68
69	Electrocardiology	659,238		659,238		659,238	69
71	Medical Supplies Charged to Patients	13,895,054		13,895,054		13,895,054	71
73	Drugs Charged to Patients	22,566,262		22,566,262		22,566,262	73
74	Renal Dialysis	6,161,029		6,161,029		6,161,029	74
75	ASC (Non-Distinct Part)	4,947,962		4,947,962		4,947,962	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	743,505		743,505		743,505	76.01
76.02	GI	2,298,629		2,298,629		2,298,629	76.02
76.03	NUCLEAR MED	885,382		885,382		885,382	76.03
76.04	PSYCH	3,542,065		3,542,065		3,542,065	76.04
76.05	ULTRASOUND	1,089,069		1,089,069		1,089,069	76.05
76.06	VASCULAR LAB	1,322,737		1,322,737		1,322,737	76.06
76.07	MEDICAL OUTPATIENT	746,501		746,501		746,501	76.07
76.97	CARDIAC REHABILITATION	496,030		496,030		496,030	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	442,559		442,559		442,559	76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic				203,415	203,415	90
91	Emergency	10,706,453		10,706,453		10,706,453	91
92	Observation Beds (Non-Distinct Part)	1,293,079		1,293,079		1,293,079	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,932,672		2,932,672		2,932,672	101
113	Interest Expense						113
116	Hospice	6,424,353		6,424,353		6,424,353	116
200	Subtotal (sum of lines 30 thru 199)	151,291,197		151,291,197	203,415	151,494,612	200
201	Less Observation Beds	1,293,079		1,293,079		1,293,079	201
202	Total (line 200 minus line 201)	149,998,118		149,998,118		150,201,533	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	23,279,642		23,279,642				30
31	Intensive Care Unit	9,805,104		9,805,104				31
43	Nursery	1,448,593		1,448,593				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,745,943	16,280,680	31,026,623	0.246140	0.246140	0.246140	50
51	Recovery Room	923,785	4,246,572	5,170,357	0.147189	0.147189	0.147189	51
52	Delivery Room & Labor Room	3,058,408	989,203	4,047,611	0.212932	0.212932	0.212932	52
53	Anesthesiology	2,309,066	3,453,853	5,762,919	0.081474	0.081474	0.081474	53
54	Radiology-Diagnostic	3,157,156	13,964,500	17,121,656	0.233709	0.233709	0.233709	54
55	Radiology-Therapeutic	227,215	8,841,280	9,068,495	0.209980	0.209980	0.209980	55
57	CT Scan	11,954,216	38,723,773	50,677,989	0.053176	0.053176	0.053176	57
58	MRI	3,535,331	15,296,800	18,832,131	0.071238	0.071238	0.071238	58
59	Cardiac Catheterization	9,831,640	10,785,550	20,617,190	0.247402	0.247402	0.247402	59
60	Laboratory	28,478,932	64,089,041	92,567,973	0.147488	0.147488	0.147488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,628,665	2,253,965	5,882,630	0.382315	0.382315	0.382315	65
66	Physical Therapy	1,757,855	10,931,697	12,689,552	0.300077	0.300077	0.300077	66
67	Occupational Therapy	653,489	1,062,239	1,715,728	0.238297	0.238297	0.238297	67
68	Speech Pathology	284,688	471,478	756,166	0.383627	0.383627	0.383627	68
69	Electrocardiology	4,822,537	11,001,809	15,824,346	0.041660	0.041660	0.041660	69
71	Medical Supplies Charged to Patients	55,237,326	50,269,630	105,506,956	0.131698	0.131698	0.131698	71
73	Drugs Charged to Patients	21,098,135	66,558,740	87,656,875	0.257439	0.257439	0.257439	73
74	Renal Dialysis	805,182	16,280,169	17,085,351	0.360603	0.360603	0.360603	74
75	ASC (Non-Distinct Part)		6,845,434	6,845,434	0.722812	0.722812	0.722812	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	88,695	2,104,188	2,192,883	0.339054	0.339054	0.339054	76.01
76.02	GI	1,511,145	18,446,127	19,957,272	0.115178	0.115178	0.115178	76.02
76.03	NUCLEAR MED	1,056,102	8,399,972	9,456,074	0.093631	0.093631	0.093631	76.03
76.04	PSYCH		3,342,210	3,342,210	1.059797	1.059797	1.059797	76.04
76.05	ULTRASOUND	1,019,126	7,388,171	8,407,297	0.129539	0.129539	0.129539	76.05
76.06	VASCULAR LAB	1,730,040	3,816,474	5,546,514	0.238481	0.238481	0.238481	76.06
76.07	MEDICAL OUTPATIENT		842,217	842,217	0.886352	0.886352	0.886352	76.07
76.97	CARDIAC REHABILITATION	2,262	1,359,694	1,361,956	0.364204	0.364204	0.364204	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	117,249	3,570,371	3,687,620	0.120012	0.120012	0.120012	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,182,831	31,623,755	39,806,586	0.268962	0.268962	0.268962	91
92	Observation Beds (Non-Distinct Part)		1,293,700	1,293,700	0.999520	0.999520	0.999520	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,990,095	1,990,095				101
113	Interest Expense							113
116	Hospice		4,875,165	4,875,165				116
200	Subtotal (sum of lines 30 thru 199)	214,750,358	431,398,552	646,148,910				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,750,358	431,398,552	646,148,910				202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
116	Hospice						116
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	23,279,642		23,279,642				30
31	Intensive Care Unit	9,805,104		9,805,104				31
43	Nursery	1,448,593		1,448,593				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,745,943	16,280,680	31,026,623				50
51	Recovery Room	923,785	4,246,572	5,170,357				51
52	Delivery Room & Labor Room	3,058,408	989,203	4,047,611				52
53	Anesthesiology	2,309,066	3,453,853	5,762,919				53
54	Radiology-Diagnostic	3,157,156	13,964,500	17,121,656				54
55	Radiology-Therapeutic	227,215	8,841,280	9,068,495				55
57	CT Scan	11,954,216	38,723,773	50,677,989				57
58	MRI	3,535,331	15,296,800	18,832,131				58
59	Cardiac Catheterization	9,831,640	10,785,550	20,617,190				59
60	Laboratory	28,478,932	64,089,041	92,567,973				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,628,665	2,253,965	5,882,630				65
66	Physical Therapy	1,757,855	10,931,697	12,689,552				66
67	Occupational Therapy	653,489	1,062,239	1,715,728				67
68	Speech Pathology	284,688	471,478	756,166				68
69	Electrocardiology	4,822,537	11,001,809	15,824,346				69
71	Medical Supplies Charged to Patients	55,237,326	50,269,630	105,506,956				71
73	Drugs Charged to Patients	21,098,135	66,558,740	87,656,875				73
74	Renal Dialysis	805,182	16,280,169	17,085,351				74
75	ASC (Non-Distinct Part)		6,845,434	6,845,434				75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	88,695	2,104,188	2,192,883				76.01
76.02	GI	1,511,145	18,446,127	19,957,272				76.02
76.03	NUCLEAR MED	1,056,102	8,399,972	9,456,074				76.03
76.04	PSYCH		3,342,210	3,342,210				76.04
76.05	ULTRASOUND	1,019,126	7,388,171	8,407,297				76.05
76.06	VASCULAR LAB	1,730,040	3,816,474	5,546,514				76.06
76.07	MEDICAL OUTPATIENT		842,217	842,217				76.07
76.97	CARDIAC REHABILITATION	2,262	1,359,694	1,361,956				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	117,249	3,570,371	3,687,620				76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,182,831	31,623,755	39,806,586				91
92	Observation Beds (Non-Distinct Part)		1,293,700	1,293,700				92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,990,095	1,990,095				101
113	Interest Expense							113
116	Hospice		4,875,165	4,875,165				116
200	Subtotal (sum of lines 30 thru 199)	214,750,358	431,398,552	646,148,910				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,750,358	431,398,552	646,148,910				202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	19,818,600		19,818,600		19,818,600	30
31	Intensive Care Unit	4,788,032		4,788,032		4,788,032	31
43	Nursery	351,388		351,388		351,388	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,636,891		7,636,891		7,636,891	50
51	Recovery Room	761,021		761,021		761,021	51
52	Delivery Room & Labor Room	861,867		861,867		861,867	52
53	Anesthesiology	469,526		469,526		469,526	53
54	Radiology-Diagnostic	4,001,492		4,001,492		4,001,492	54
55	Radiology-Therapeutic	1,904,201		1,904,201		1,904,201	55
57	CT Scan	2,694,840		2,694,840		2,694,840	57
58	MRI	1,341,566		1,341,566		1,341,566	58
59	Cardiac Catheterization	5,100,728		5,100,728		5,100,728	59
60	Laboratory	13,652,669		13,652,669		13,652,669	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,249,019		2,249,019		2,249,019	65
66	Physical Therapy	3,807,839		3,807,839		3,807,839	66
67	Occupational Therapy	408,853		408,853		408,853	67
68	Speech Pathology	290,086		290,086		290,086	68
69	Electrocardiology	659,238		659,238		659,238	69
71	Medical Supplies Charged to Patients	13,895,054		13,895,054		13,895,054	71
73	Drugs Charged to Patients	22,566,262		22,566,262		22,566,262	73
74	Renal Dialysis	6,161,029		6,161,029		6,161,029	74
75	ASC (Non-Distinct Part)	4,947,962		4,947,962		4,947,962	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	743,505		743,505		743,505	76.01
76.02	GI	2,298,629		2,298,629		2,298,629	76.02
76.03	NUCLEAR MED	885,382		885,382		885,382	76.03
76.04	PSYCH	3,542,065		3,542,065		3,542,065	76.04
76.05	ULTRASOUND	1,089,069		1,089,069		1,089,069	76.05
76.06	VASCULAR LAB	1,322,737		1,322,737		1,322,737	76.06
76.07	MEDICAL OUTPATIENT	746,501		746,501		746,501	76.07
76.97	CARDIAC REHABILITATION	496,030		496,030		496,030	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	442,559		442,559		442,559	76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic				203,415	203,415	90
91	Emergency	10,706,453		10,706,453		10,706,453	91
92	Observation Beds (Non-Distinct Part)	1,293,079		1,293,079		1,293,079	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	2,932,672		2,932,672		2,932,672	101
113	Interest Expense						113
116	Hospice	6,424,353		6,424,353		6,424,353	116
200	Subtotal (sum of lines 30 thru 199)	151,291,197		151,291,197	203,415	151,494,612	200
201	Less Observation Beds	1,293,079		1,293,079		1,293,079	201
202	Total (line 200 minus line 201)	149,998,118		149,998,118	203,415	150,201,533	202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	23,279,642		23,279,642				30
31	Intensive Care Unit	9,805,104		9,805,104				31
43	Nursery	1,448,593		1,448,593				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,745,943	16,280,680	31,026,623	0.246140	0.246140	0.246140	50
51	Recovery Room	923,785	4,246,572	5,170,357	0.147189	0.147189	0.147189	51
52	Delivery Room & Labor Room	3,058,408	989,203	4,047,611	0.212932	0.212932	0.212932	52
53	Anesthesiology	2,309,066	3,453,853	5,762,919	0.081474	0.081474	0.081474	53
54	Radiology-Diagnostic	3,157,156	13,964,500	17,121,656	0.233709	0.233709	0.233709	54
55	Radiology-Therapeutic	227,215	8,841,280	9,068,495	0.209980	0.209980	0.209980	55
57	CT Scan	11,954,216	38,723,773	50,677,989	0.053176	0.053176	0.053176	57
58	MRI	3,535,331	15,296,800	18,832,131	0.071238	0.071238	0.071238	58
59	Cardiac Catheterization	9,831,640	10,785,550	20,617,190	0.247402	0.247402	0.247402	59
60	Laboratory	28,478,932	64,089,041	92,567,973	0.147488	0.147488	0.147488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,628,665	2,253,965	5,882,630	0.382315	0.382315	0.382315	65
66	Physical Therapy	1,757,855	10,931,697	12,689,552	0.300077	0.300077	0.300077	66
67	Occupational Therapy	653,489	1,062,239	1,715,728	0.238297	0.238297	0.238297	67
68	Speech Pathology	284,688	471,478	756,166	0.383627	0.383627	0.383627	68
69	Electrocardiology	4,822,537	11,001,809	15,824,346	0.041660	0.041660	0.041660	69
71	Medical Supplies Charged to Patients	55,237,326	50,269,630	105,506,956	0.131698	0.131698	0.131698	71
73	Drugs Charged to Patients	21,098,135	66,558,740	87,656,875	0.257439	0.257439	0.257439	73
74	Renal Dialysis	805,182	16,280,169	17,085,351	0.360603	0.360603	0.360603	74
75	ASC (Non-Distinct Part)		6,845,434	6,845,434	0.722812	0.722812	0.722812	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	88,695	2,104,188	2,192,883	0.339054	0.339054	0.339054	76.01
76.02	GI	1,511,145	18,446,127	19,957,272	0.115178	0.115178	0.115178	76.02
76.03	NUCLEAR MED	1,056,102	8,399,972	9,456,074	0.093631	0.093631	0.093631	76.03
76.04	PSYCH		3,342,210	3,342,210	1.059797	1.059797	1.059797	76.04
76.05	ULTRASOUND	1,019,126	7,388,171	8,407,297	0.129539	0.129539	0.129539	76.05
76.06	VASCULAR LAB	1,730,040	3,816,474	5,546,514	0.238481	0.238481	0.238481	76.06
76.07	MEDICAL OUTPATIENT		842,217	842,217	0.886352	0.886352	0.886352	76.07
76.97	CARDIAC REHABILITATION	2,262	1,359,694	1,361,956	0.364204	0.364204	0.364204	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	117,249	3,570,371	3,687,620	0.120012	0.120012	0.120012	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,182,831	31,623,755	39,806,586	0.268962	0.268962	0.268962	91
92	Observation Beds (Non-Distinct Part)		1,293,700	1,293,700	0.999520	0.999520	0.999520	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,990,095	1,990,095				101
113	Interest Expense							113
116	Hospice		4,875,165	4,875,165				116
200	Subtotal (sum of lines 30 thru 199)	214,750,358	431,398,552	646,148,910				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,750,358	431,398,552	646,148,910				202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	7,636,891	1,015,512	6,621,379		50
51	Recovery Room	761,021	50,622	710,399		51
52	Delivery Room & Labor Room	861,867	25,877	835,990		52
53	Anesthesiology	469,526	48,591	420,935		53
54	Radiology-Diagnostic	4,001,492	542,122	3,459,370		54
55	Radiology-Therapeutic	1,904,201	262,564	1,641,637		55
57	CT Scan	2,694,840	242,250	2,452,590		57
58	MRI	1,341,566	183,890	1,157,676		58
59	Cardiac Catheterization	5,100,728	932,976	4,167,752		59
60	Laboratory	13,652,669	867,100	12,785,569		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,249,019	168,271	2,080,748		65
66	Physical Therapy	3,807,839	469,311	3,338,528		66
67	Occupational Therapy	408,853	26,896	381,957		67
68	Speech Pathology	290,086	17,287	272,799		68
69	Electrocardiology	659,238	42,607	616,631		69
71	Medical Supplies Charged to Patients	13,895,054	368,589	13,526,465		71
73	Drugs Charged to Patients	22,566,262	767,584	21,798,678		73
74	Renal Dialysis	6,161,029	389,992	5,771,037		74
75	ASC (Non-Distinct Part)	4,947,962	1,472,537	3,475,425		75
76	OTHER ANCILLARY					76
76.01	SLEEP/EEG	743,505	44,938	698,567		76.01
76.02	GI	2,298,629	382,931	1,915,698		76.02
76.03	NUCLEAR MED	885,382	52,503	832,879		76.03
76.04	PSYCH	3,542,065	217,800	3,324,265		76.04
76.05	ULTRASOUND	1,089,069	147,751	941,318		76.05
76.06	VASCULAR LAB	1,322,737	152,747	1,169,990		76.06
76.07	MEDICAL OUTPATIENT	746,501	43,402	703,099		76.07
76.97	CARDIAC REHABILITATION	496,030	48,641	447,389		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY	442,559	11,690	430,869		76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic					90
91	Emergency	10,706,453	1,316,956	9,389,497		91
92	Observation Beds (Non-Distinct Part)	1,293,079	107,483	1,185,596		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	2,932,672	148,454	2,784,218		101
113	Interest Expense					113
116	Hospice	6,424,353	265,639	6,158,714		116
200	Subtotal	126,333,177	10,835,513	115,497,664		200
201	Less Observation Beds	1,293,079	107,483	1,185,596		201
202	Total	125,040,098	10,728,030	114,312,068		202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		7,636,891	31,026,623	0.246140	50
51	Recovery Room		761,021	5,170,357	0.147189	51
52	Delivery Room & Labor Room		861,867	4,047,611	0.212932	52
53	Anesthesiology		469,526	5,762,919	0.081474	53
54	Radiology-Diagnostic		4,001,492	17,121,656	0.233709	54
55	Radiology-Therapeutic		1,904,201	9,068,495	0.209980	55
57	CT Scan		2,694,840	50,677,989	0.053176	57
58	MRI		1,341,566	18,832,131	0.071238	58
59	Cardiac Catheterization		5,100,728	20,617,190	0.247402	59
60	Laboratory		13,652,669	92,567,973	0.147488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		2,249,019	5,882,630	0.382315	65
66	Physical Therapy		3,807,839	12,689,552	0.300077	66
67	Occupational Therapy		408,853	1,715,728	0.238297	67
68	Speech Pathology		290,086	756,166	0.383627	68
69	Electrocardiology		659,238	15,824,346	0.041660	69
71	Medical Supplies Charged to Patients		13,895,054	105,506,956	0.131698	71
73	Drugs Charged to Patients		22,566,262	87,656,875	0.257439	73
74	Renal Dialysis		6,161,029	17,085,351	0.360603	74
75	ASC (Non-Distinct Part)		4,947,962	6,845,434	0.722812	75
76	OTHER ANCILLARY					76
76.01	SLEEP/EEG		743,505	2,192,883	0.339054	76.01
76.02	GI		2,298,629	19,957,272	0.115178	76.02
76.03	NUCLEAR MED		885,382	9,456,074	0.093631	76.03
76.04	PSYCH		3,542,065	3,342,210	1.059797	76.04
76.05	ULTRASOUND		1,089,069	8,407,297	0.129539	76.05
76.06	VASCULAR LAB		1,322,737	5,546,514	0.238481	76.06
76.07	MEDICAL OUTPATIENT		746,501	842,217	0.886352	76.07
76.97	CARDIAC REHABILITATION		496,030	1,361,956	0.364204	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY		442,559	3,687,620	0.120012	76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic					90
91	Emergency		10,706,453	39,806,586	0.268962	91
92	Observation Beds (Non-Distinct Part)		1,293,079	1,293,700	0.999520	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		2,932,672	1,990,095	1.473634	101
113	Interest Expense					113
116	Hospice		6,424,353	4,875,165	1.317771	116
200	Subtotal		126,333,177	611,615,571		200
201	Less Observation Beds		1,293,079	1,293,700		201
202	Total		125,040,098	610,321,871		202

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,647,366		1,647,366	15,296	107.70	6,998	753,685	30
31	Intensive Care Unit	347,971		347,971	2,106	165.23	926	153,003	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	10,868		10,868	816	13.32			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,006,205		2,006,205	18,218		7,924	906,688	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 52-0100****WORKSHEET D
PART II**

Check ☐ Title V **[XX]** Hospital ☐ SUB (Other) **[XX]** PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,015,512	31,026,623	0.032730	5,449,387	178,358	50
51	Recovery Room	50,622	5,170,357	0.009791	311,707	3,052	51
52	Delivery Room & Labor Room	25,877	4,047,611	0.006393	22,455	144	52
53	Anesthesiology	48,591	5,762,919	0.008432	792,926	6,686	53
54	Radiology-Diagnostic	542,122	17,121,656	0.031663	1,545,270	48,928	54
55	Radiology-Therapeutic	262,564	9,068,495	0.028953	136,239	3,945	55
57	CT Scan	242,250	50,677,989	0.004780	5,713,380	27,310	57
58	MRI	183,890	18,832,131	0.009765	1,688,549	16,489	58
59	Cardiac Catheterization	932,976	20,617,190	0.045252	4,327,138	195,812	59
60	Laboratory	867,100	92,567,973	0.009367	13,116,252	122,860	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,271	5,882,630	0.028605	1,634,521	46,755	65
66	Physical Therapy	469,311	12,689,552	0.036984	908,698	33,607	66
67	Occupational Therapy	26,896	1,715,728	0.015676	386,724	6,062	67
68	Speech Pathology	17,287	756,166	0.022861	187,894	4,295	68
69	Electrocardiology	42,607	15,824,346	0.002692	2,424,452	6,527	69
71	Medical Supplies Charged to Pat	368,589	105,506,956	0.003494	24,206,790	84,579	71
73	Drugs Charged to Patients	767,584	87,656,875	0.008757	9,362,184	81,985	73
74	Renal Dialysis	389,992	17,085,351	0.022826	520,138	11,873	74
75	ASC (Non-Distinct Part)	1,472,537	6,845,434	0.215112			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	44,938	2,192,883	0.020493	42,342	868	76.01
76.02	GI	382,931	19,957,272	0.019188	821,505	15,763	76.02
76.03	NUCLEAR MED	52,503	9,456,074	0.005552	633,717	3,518	76.03
76.04	PSYCH	217,800	3,342,210	0.065166			76.04
76.05	ULTRASOUND	147,751	8,407,297	0.017574	440,448	7,740	76.05
76.06	VASCULAR LAB	152,747	5,546,514	0.027539	655,260	18,045	76.06
76.07	MEDICAL OUTPATIENT	43,402	842,217	0.051533			76.07
76.97	CARDIAC REHABILITATION	48,641	1,361,956	0.035714	1,153	41	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	11,690	3,687,620	0.003170			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,316,956	39,806,586	0.033084	3,705,598	122,596	91
92	Observation Beds (Non-Distinct	107,483	1,293,700	0.083082			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	10,421,420	604,750,311		79,034,727	1,047,838	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	15,296		6,998		30
31	Intensive Care Unit	2,106		926		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	816				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	18,218		7,924		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	31,026,623			5,449,387		8,113,114		50
51	Recovery Room	5,170,357			311,707		1,240,938		51
52	Delivery Room & Labor Room	4,047,611			22,455		6,273		52
53	Anesthesiology	5,762,919			792,926		954,375		53
54	Radiology-Diagnostic	17,121,656			1,545,270		4,377,158		54
55	Radiology-Therapeutic	9,068,495			136,239		3,515,113		55
57	CT Scan	50,677,989			5,713,380		11,928,361		57
58	MRI	18,832,131			1,688,549		4,228,121		58
59	Cardiac Catheterization	20,617,190			4,327,138		4,625,417		59
60	Laboratory	92,567,973			13,116,252		12,191,316		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,882,630			1,634,521		730,646		65
66	Physical Therapy	12,689,552			908,698		231,196		66
67	Occupational Therapy	1,715,728			386,724		10,444		67
68	Speech Pathology	756,166			187,894		1,061		68
69	Electrocardiology	15,824,346			2,424,452		4,059,246		69
71	Medical Supplies Charged to Pat	105,506,956			24,206,790		15,497,271		71
73	Drugs Charged to Patients	87,656,875			9,362,184		28,886,417		73
74	Renal Dialysis	17,085,351			520,138		17,980		74
75	ASC (Non-Distinct Part)	6,845,434							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	2,192,883			42,342		659,809		76.01
76.02	GI	19,957,272			821,505		4,925,518		76.02
76.03	NUCLEAR MED	9,456,074			633,717		3,484,869		76.03
76.04	PSYCH	3,342,210					627,688		76.04
76.05	ULTRASOUND	8,407,297			440,448		1,597,955		76.05
76.06	VASCULAR LAB	5,546,514			655,260		1,322,746		76.06
76.07	MEDICAL OUTPATIENT	842,217							76.07
76.97	CARDIAC REHABILITATION	1,361,956			1,153		640,059		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	3,687,620							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	39,806,586			3,705,598		5,733,536		91
92	Observation Beds (Non-Distinct	1,293,700					400,106		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	604,750,311			79,034,727		120,006,733		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.246140	8,113,114			1,996,962			50
51	Recovery Room	0.147189	1,240,938			182,652			51
52	Delivery Room & Labor Room	0.212932	6,273			1,336			52
53	Anesthesiology	0.081474	954,375			77,757			53
54	Radiology-Diagnostic	0.233709	4,377,158			1,022,981			54
55	Radiology-Therapeutic	0.209980	3,515,113			738,103			55
57	CT Scan	0.053176	11,928,361			634,303			57
58	MRI	0.071238	4,228,121			301,203			58
59	Cardiac Catheterization	0.247402	4,625,417			1,144,337			59
60	Laboratory	0.147488	12,191,316			1,798,073			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.382315	730,646			279,337			65
66	Physical Therapy	0.300077	231,196			69,377			66
67	Occupational Therapy	0.238297	10,444			2,489			67
68	Speech Pathology	0.383627	1,061			407			68
69	Electrocardiology	0.041660	4,059,246			169,108			69
71	Medical Supplies Charged to Pat	0.131698	15,497,271			2,040,960			71
73	Drugs Charged to Patients	0.257439	28,886,417	1,988	304,370	7,436,490	512	78,357	73
74	Renal Dialysis	0.360603	17,980			6,484			74
75	ASC (Non-Distinct Part)	0.722812							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	0.339054	659,809			223,711			76.01
76.02	GI	0.115178	4,925,518			567,311			76.02
76.03	NUCLEAR MED	0.093631	3,484,869			326,292			76.03
76.04	PSYCH	1.059797	627,688			665,222			76.04
76.05	ULTRASOUND	0.129539	1,597,955			206,997			76.05
76.06	VASCULAR LAB	0.238481	1,322,746			315,450			76.06
76.07	MEDICAL OUTPATIENT	0.886352							76.07
76.97	CARDIAC REHABILITATION	0.364204	640,059			233,112			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	0.120012							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	0.268962	5,733,536			1,542,103			91
92	Observation Beds (Non-Distinct	0.999520	400,106			399,914			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		120,006,733	1,988	304,370	22,382,471	512	78,357	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		120,006,733	1,988	304,370	22,382,471	512	78,357	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,647,366		1,647,366	15,296	107.70	557	59,989	30
31	Intensive Care Unit	347,971		347,971	2,106	165.23	34	5,618	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	10,868		10,868	816	13.32	132	1,758	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,006,205		2,006,205	18,218		723	67,365	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,015,512	31,026,623	0.032730	444,645	14,553	50
51	Recovery Room	50,622	5,170,357	0.009791	35,340	346	51
52	Delivery Room & Labor Room	25,877	4,047,611	0.006393	360,623	2,305	52
53	Anesthesiology	48,591	5,762,919	0.008432	62,229	525	53
54	Radiology-Diagnostic	542,122	17,121,656	0.031663	101,093	3,201	54
55	Radiology-Therapeutic	262,564	9,068,495	0.028953			55
57	CT Scan	242,250	50,677,989	0.004780	490,428	2,344	57
58	MRI	183,890	18,832,131	0.009765	167,472	1,635	58
59	Cardiac Catheterization	932,976	20,617,190	0.045252	406,623	18,401	59
60	Laboratory	867,100	92,567,973	0.009367	1,187,420	11,123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,271	5,882,630	0.028605	178,149	5,096	65
66	Physical Therapy	469,311	12,689,552	0.036984	43,958	1,626	66
67	Occupational Therapy	26,896	1,715,728	0.015676	5,617	88	67
68	Speech Pathology	17,287	756,166	0.022861	2,716	62	68
69	Electrocardiology	42,607	15,824,346	0.002692	143,115	385	69
71	Medical Supplies Charged to Pat	368,589	105,506,956	0.003494	1,465,560	5,121	71
73	Drugs Charged to Patients	767,584	87,656,875	0.008757	768,389	6,729	73
74	Renal Dialysis	389,992	17,085,351	0.022826	41,834	955	74
75	ASC (Non-Distinct Part)	1,472,537	6,845,434	0.215112			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	44,938	2,192,883	0.020493	3,867	79	76.01
76.02	GI	382,931	19,957,272	0.019188	24,920	478	76.02
76.03	NUCLEAR MED	52,503	9,456,074	0.005552	31,127	173	76.03
76.04	PSYCH	217,800	3,342,210	0.065166			76.04
76.05	ULTRASOUND	147,751	8,407,297	0.017574	52,783	928	76.05
76.06	VASCULAR LAB	152,747	5,546,514	0.027539	104,143	2,868	76.06
76.07	MEDICAL OUTPATIENT	43,402	842,217	0.051533			76.07
76.97	CARDIAC REHABILITATION	48,641	1,361,956	0.035714			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	11,690	3,687,620	0.003170			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,316,956	39,806,586	0.033084	382,691	12,661	91
92	Observation Beds (Non-Distinct	107,483	1,293,700	0.083082			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	10,421,420	604,750,311		6,504,742	91,682	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	15,296		557		30
31	Intensive Care Unit	2,106		34		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	816		132		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	18,218		723		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	31,026,623			444,645				50
51	Recovery Room	5,170,357			35,340				51
52	Delivery Room & Labor Room	4,047,611			360,623				52
53	Anesthesiology	5,762,919			62,229				53
54	Radiology-Diagnostic	17,121,656			101,093				54
55	Radiology-Therapeutic	9,068,495							55
57	CT Scan	50,677,989			490,428				57
58	MRI	18,832,131			167,472				58
59	Cardiac Catheterization	20,617,190			406,623				59
60	Laboratory	92,567,973			1,187,420				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,882,630			178,149				65
66	Physical Therapy	12,689,552			43,958				66
67	Occupational Therapy	1,715,728			5,617				67
68	Speech Pathology	756,166			2,716				68
69	Electrocardiology	15,824,346			143,115				69
71	Medical Supplies Charged to Pat	105,506,956			1,465,560				71
73	Drugs Charged to Patients	87,656,875			768,389				73
74	Renal Dialysis	17,085,351			41,834				74
75	ASC (Non-Distinct Part)	6,845,434							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	2,192,883			3,867				76.01
76.02	GI	19,957,272			24,920				76.02
76.03	NUCLEAR MED	9,456,074			31,127				76.03
76.04	PSYCH	3,342,210							76.04
76.05	ULTRASOUND	8,407,297			52,783				76.05
76.06	VASCULAR LAB	5,546,514			104,143				76.06
76.07	MEDICAL OUTPATIENT	842,217							76.07
76.97	CARDIAC REHABILITATION	1,361,956							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	3,687,620							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	39,806,586			382,691				91
92	Observation Beds (Non-Distinct	1,293,700							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	604,750,311			6,504,742				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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.246140		627,867			154,543		50
51	Recovery Room	0.147189		103,012			15,162		51
52	Delivery Room & Labor Room	0.212932		77,357			16,472		52
53	Anesthesiology	0.081474		87,618			7,139		53
54	Radiology-Diagnostic	0.233709		558,423			130,508		54
55	Radiology-Therapeutic	0.209980		388,091			81,491		55
57	CT Scan	0.053176		1,515,895			80,609		57
58	MRI	0.071238		332,522			23,688		58
59	Cardiac Catheterization	0.247402		267,320			66,136		59
60	Laboratory	0.147488		3,313,345			488,679		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.382315		125,937			48,148		65
66	Physical Therapy	0.300077		223,395			67,036		66
67	Occupational Therapy	0.238297		10,750			2,562		67
68	Speech Pathology	0.383627		124,603			47,801		68
69	Electrocardiology	0.041660		251,377			10,472		69
71	Medical Supplies Charged to Pat	0.131698		1,269,686			167,215		71
73	Drugs Charged to Patients	0.257439		2,106,985			542,420		73
74	Renal Dialysis	0.360603		762,799			275,068		74
75	ASC (Non-Distinct Part)	0.722812							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	0.339054		42,048			14,257		76.01
76.02	GI	0.115178		263,836			30,388		76.02
76.03	NUCLEAR MED	0.093631		155,306			14,541		76.03
76.04	PSYCH	1.059797		778,561			825,117		76.04
76.05	ULTRASOUND	0.129539		586,854			76,020		76.05
76.06	VASCULAR LAB	0.238481		166,574			39,725		76.06
76.07	MEDICAL OUTPATIENT	0.886352							76.07
76.97	CARDIAC REHABILITATION	0.364204		28,063			10,221		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	0.120012							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	0.268962		2,608,996			701,721		91
92	Observation Beds (Non-Distinct	0.999520		61,902			61,872		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			16,839,122			3,999,011		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			16,839,122			3,999,011		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	15,296	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,296	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)	14,298	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)	6,998	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)	19,818,600	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)	19,818,600	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 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)	19,818,600	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)					1,295.67	38
39	Program general inpatient routine service cost (line 9 x line 38)					9,067,099	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)					9,067,099	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	4,788,032	2,106	2,273.52	926	2,105,280	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,602,742	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	24,775,121	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	906,688	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,047,838	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,954,526	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	22,820,595	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					998	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,295.67	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,293,079	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	1,647,366	19,818,600	0.083122	1,293,079	107,483	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	15,296	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,296	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)	14,298	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)	557	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)	816	15
16	Nursery days (title V or XIX only)	132	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)	19,818,600	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)	19,818,600	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 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)	19,818,600	37

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)					1,295.67	38
39	Program general inpatient routine service cost (line 9 x line 38)					721,688	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)					721,688	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)	351,388	816	430.62	132	56,842	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,788,032	2,106	2,273.52	34	77,300	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)	1,171,118	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,026,948	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	67,365	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	91,682	51
52	Total Program excludable cost (sum of lines 50 and 51)	159,047	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					998	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,982,385		30
31	Intensive Care Unit		4,382,196		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.246140	5,449,387	1,341,312	50
51	Recovery Room	0.147189	311,707	45,880	51
52	Delivery Room & Labor Room	0.212932	22,455	4,781	52
53	Anesthesiology	0.081474	792,926	64,603	53
54	Radiology-Diagnostic	0.233709	1,545,270	361,144	54
55	Radiology-Therapeutic	0.209980	136,239	28,607	55
57	CT Scan	0.053176	5,713,380	303,815	57
58	MRI	0.071238	1,688,549	120,289	58
59	Cardiac Catheterization	0.247402	4,327,138	1,070,543	59
60	Laboratory	0.147488	13,116,252	1,934,490	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.382315	1,634,521	624,902	65
66	Physical Therapy	0.300077	908,698	272,679	66
67	Occupational Therapy	0.238297	386,724	92,155	67
68	Speech Pathology	0.383627	187,894	72,081	68
69	Electrocardiology	0.041660	2,424,452	101,003	69
71	Medical Supplies Charged to Patients	0.131698	24,206,790	3,187,986	71
73	Drugs Charged to Patients	0.257439	9,362,184	2,410,191	73
74	Renal Dialysis	0.360603	520,138	187,563	74
75	ASC (Non-Distinct Part)	0.722812			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.339054	42,342	14,356	76.01
76.02	GI	0.115178	821,505	94,619	76.02
76.03	NUCLEAR MED	0.093631	633,717	59,336	76.03
76.04	PSYCH	1.059797			76.04
76.05	ULTRASOUND	0.129539	440,448	57,055	76.05
76.06	VASCULAR LAB	0.238481	655,260	156,267	76.06
76.07	MEDICAL OUTPATIENT	0.886352			76.07
76.97	CARDIAC REHABILITATION	0.364204	1,153	420	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	0.120012			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.268962	3,705,598	996,665	91
92	Observation Beds (Non-Distinct Part)	0.999520			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		79,034,727	13,602,742	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		79,034,727		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		826,636		30
31	Intensive Care Unit		446,162		31
43	Nursery		246,810		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.246140	444,645	109,445	50
51	Recovery Room	0.147189	35,340	5,202	51
52	Delivery Room & Labor Room	0.212932	360,623	76,788	52
53	Anesthesiology	0.081474	62,229	5,070	53
54	Radiology-Diagnostic	0.233709	101,093	23,626	54
55	Radiology-Therapeutic	0.209980			55
57	CT Scan	0.053176	490,428	26,079	57
58	MRI	0.071238	167,472	11,930	58
59	Cardiac Catheterization	0.247402	406,623	100,599	59
60	Laboratory	0.147488	1,187,420	175,130	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.382315	178,149	68,109	65
66	Physical Therapy	0.300077	43,958	13,191	66
67	Occupational Therapy	0.238297	5,617	1,339	67
68	Speech Pathology	0.383627	2,716	1,042	68
69	Electrocardiology	0.041660	143,115	5,962	69
71	Medical Supplies Charged to Patients	0.131698	1,465,560	193,011	71
73	Drugs Charged to Patients	0.257439	768,389	197,813	73
74	Renal Dialysis	0.360603	41,834	15,085	74
75	ASC (Non-Distinct Part)	0.722812			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.339054	3,867	1,311	76.01
76.02	GI	0.115178	24,920	2,870	76.02
76.03	NUCLEAR MED	0.093631	31,127	2,914	76.03
76.04	PSYCH	1.059797			76.04
76.05	ULTRASOUND	0.129539	52,783	6,837	76.05
76.06	VASCULAR LAB	0.238481	104,143	24,836	76.06
76.07	MEDICAL OUTPATIENT	0.886352			76.07
76.97	CARDIAC REHABILITATION	0.364204			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	0.120012			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.268962	382,691	102,929	91
92	Observation Beds (Non-Distinct Part)	0.999520			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,504,742	1,171,118	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,504,742		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	11,179,563			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,437,976			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)	735,969			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	100.27			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)	0.0522			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1827			31
32	Sum of lines 30 and 31	0.2349			32
33	Allowable disproportionate share percentage (see instructions)	0.0859			33
34	Disproportionate share adjustment (see instructions)	335,387			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	6,766,695,164		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000139349		0.000140902	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	942,932		1,165,664	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	705,261		293,811	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	999,072			36

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	17,687,967			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)	17,687,967			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,331,365			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	19,019,332			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	19,019,332			61
62	Deductibles billed to program beneficiaries	1,811,392			62
63	Coinsurance billed to program beneficiaries	6,030			63
64	Allowable bad debts (see instructions)	253,808			64
65	Adjusted reimbursable bad debts (see instructions)	164,975			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	253,808			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	17,366,885			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)	-29,387			70.93
70.94	HRR adjustment amount (see instructions)	-132,895			70.94
71	Amount due provider (see instructions)	17,204,603			71
71.01	Sequestration adjustment (see instructions)	344,092			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	16,675,519			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	184,992			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2				75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 52-0100****WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	78,869			1
2	Medical and other services reimbursed under OPPS (see instructions)	22,382,471			2
3	OPPS payments	28,924,071			3
4	Outlier payment (see instructions)	240,933			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.872			5
6	Line 2 times line 5	19,517,515			6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	78,869			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	306,358			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)	306,358			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)	306,358			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	227,489			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	78,869			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	29,165,004			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	5,852,909			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)	23,390,964			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)	23,390,964			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	23,390,964			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)	706,252			34
35	Adjusted reimbursable bad debts (see instructions)	459,064			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	706,252			36
37	Subtotal (see instructions)	23,850,028			37
38	MSP-LCC reconciliation amount from PS&R	1,825			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	23,848,203			40
40.01	Sequestration adjustment (see instructions)	476,964			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	22,844,042			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	527,197			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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			16,675,519		22,844,042
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			16,675,519		22,844,042
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	2,026,948		1
2	Medical and other services		3,999,011	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,026,948	3,999,011	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,026,948	3,999,011	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	6,504,742	16,839,122	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)	6,504,742	16,839,122	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrgs 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)	6,504,742	16,839,122	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,477,794	12,840,111	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)	2,026,948	3,999,011	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)	2,026,948	3,999,011	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)	2,026,948	3,999,011	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)	2,026,948	3,999,011	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,026,948	3,999,011	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)	2,026,948	3,999,011	40
41	Interim payments	1,849,881	2,438,989	41
42	Balance due provider/program (line 40 minus line 41)	177,067	1,560,022	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	

CURRENT ASSETS

1	Cash on hand and in banks	16,473,136				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	50,155,894				4
5	Other receivables	7,147,955				5
6	Allowances for uncollectible notes and accounts receivable	-3,915,000				6
7	Inventory	5,585,672				7
8	Prepaid expenses	1,289,242				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	76,736,899				11

FIXED ASSETS

12	Land	8,100,877				12
13	Land improvements	7,699,872				13
14	Accumulated depreciation	-5,262,035				14
15	Buildings	144,126,526				15
16	Accumulated depreciation	-59,956,543				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	40,816,172				19
20	Accumulated depreciation	-24,663,065				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	59,868,011				23
24	Accumulated depreciation	-45,465,049				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)	125,264,766				30

OTHER ASSETS

31	Investments	72,359,637				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,152,087				34
35	Total other assets (sum of lines 31-34)	76,511,724				35
36	Total assets (sum of lines 11, 30 and 35)	278,513,389				36

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	

CURRENT LIABILITIES

37	Accounts payable	8,567,478				37
38	Salaries, wages and fees payable	5,979,525				38
39	Payroll taxes payable	211,490				39
40	Notes and loans payable (short term)	2,875,503				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	14,591,495				44
45	Total current liabilities (sum of lines 37 thru 44)	32,225,491				45

LONG TERM LIABILITIES

46	Mortgage payable	79,005,804				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	28,749,143				49
50	Total long term liabilities (sum of lines 46 thru 49)	107,754,947				50
51	Total liabilities (sum of lines 45 and 50)	139,980,438				51

CAPITAL ACCOUNTS

52	General fund balance	138,532,951				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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	138,532,951				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	278,513,389				60

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		138,406,176		1
2	Net income (loss) (from Worksheet G-3, line 29)		9,614,538		2
3	Total (sum of line 1 and line 2)		148,020,714		3
4	Additions (credit adjustments) (specify)				4
5	CHANGE IN SWAP VALUE	1,278,331			5
6	ASSETS RELEASED FROM RESTRICTIONS	1,208,848			6
7	OTHER	45,551			7
8					8
9					9
10	Total additions (sum of lines 4-9)		2,532,730		10
11	Subtotal (line 3 plus line 10)		150,553,444		11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN UNREALIZED GAINS / LOSSES	8,602,204			13
14	CHANGE IN PENSION OBLIGATION	3,340,912			14
15	FOUNDATION RECEIVABLE WRITEDOWN	77,377			15
16					16
17					17
18	Total deductions (sum of lines 12-17)		12,020,493		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		138,532,951		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	CHANGE IN SWAP VALUE				5
6	ASSETS RELEASED FROM RESTRICTIONS				6
7	OTHER				7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN UNREALIZED GAINS / LOSSES				13
14	CHANGE IN PENSION OBLIGATION				14
15	FOUNDATION RECEIVABLE WRITEDOWN				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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	24,560,894		24,560,894	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)	24,560,894		24,560,894	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	9,694,219		9,694,219	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)	9,694,219		9,694,219	16
17	Total inpatient routine care services (sum of lines 10 and 16)	34,255,113		34,255,113	17
18	Ancillary services	179,692,585	634,768,069	814,460,654	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		1,990,095	1,990,095	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)	213,947,698	636,758,164	850,705,862	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		240,757,231	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		240,757,231	43

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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)	850,705,862	1
2	Less contractual allowances and discounts on patients' accounts	612,250,167	2
3	Net patient revenues (line 1 minus line 2)	238,455,695	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	240,757,231	4
5	Net income from service to patients (line 3 minus line 4)	-2,301,536	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	4,385,702	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)	7,979,545	24
25	Total other income (sum of lines 6-24)	12,365,247	25
26	Total (line 5 plus line 25)	10,063,711	26
27	Other expenses (OTHER NON OPERATING EXPENSE (NET))	449,173	27
28	Total other expenses (sum of line 27 and subscripts)	449,173	28
29	Net income (or loss) for the period (line 26 minus line 28)	9,614,538	29

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	203,682				140,411	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	702,508		24,420			6
7	Physical Therapy	367,221		12,765			7
8	Occupational Therapy	123,283		4,285			8
9	Speech Pathology	9,116		317			9
10	Medical Social Services						10
11	Home Health Aide	31,304		1,088			11
12	Supplies (see instructions)					31,607	12
13	Drugs					12,605	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)	1,437,114		42,875		184,623	24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	344,093		344,093	-1,680	342,413	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	726,928		726,928		726,928	6
7	Physical Therapy	379,986		379,986		379,986	7
8	Occupational Therapy	127,568		127,568		127,568	8
9	Speech Pathology	9,433		9,433		9,433	9
10	Medical Social Services						10
11	Home Health Aide	32,392		32,392		32,392	11
12	Supplies (see instructions)	31,607		31,607		31,607	12
13	Drugs	12,605		12,605		12,605	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)	1,664,612		1,664,612	-1,680	1,662,932	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	342,413				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	726,928				6
7	Physical Therapy	379,986				7
8	Occupational Therapy	127,568				8
9	Speech Pathology	9,433				9
10	Medical Social Services					10
11	Home Health Aide	32,392				11
12	Supplies (see instructions)	31,607				12
13	Drugs	12,605				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)	1,662,932				24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		342,413	342,413		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		726,928	188,493	915,421	6
7	Physical Therapy		379,986	98,531	478,517	7
8	Occupational Therapy		127,568	33,079	160,647	8
9	Speech Pathology		9,433	2,446	11,879	9
10	Medical Social Services					10
11	Home Health Aide		32,392	8,399	40,791	11
12	Supplies (see instructions)		31,607	8,196	39,803	12
13	Drugs		12,605	3,269	15,874	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)		1,662,932		1,662,932	24

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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 & MAINTENANC E (Square Feet)	TRANSPORT- ATION (Mileage)	RECONCIL- IATION	ADMINI- STRATIVE & 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		7,914					2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General	3,356	7,914			-342,413	1,320,519	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						726,928	6
7	Physical Therapy						379,986	7
8	Occupational Therapy						127,568	8
9	Speech Pathology						9,433	9
10	Medical Social Services							10
11	Home Health Aide						32,392	11
12	Supplies (see instructions)						31,607	12
13	Drugs						12,605	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	7,914			-342,413	1,320,519	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						342,413	25
26	Unit Cost Multiplier						0.259302	26

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		63,006	8,522	80,321	151,849	33,193	1
2	Skilled Nursing Care	915,421			277,029	1,192,450	260,659	2
3	Physical Therapy	478,517			144,811	623,328	136,254	3
4	Occupational Therapy	160,647			48,616	209,263	45,743	4
5	Speech Pathology	11,879			3,595	15,474	3,382	5
6	Medical Social Services							6
7	Home Health Aide	40,791			12,345	53,136	11,615	7
8	Supplies	39,803				39,803	8,701	8
9	Drugs	15,874				15,874	3,470	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)	1,662,932	63,006	8,522	566,717	2,301,177	503,017	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		83,652		20,435			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)		83,652		20,435			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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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			6,910	3,236	14,245		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)			6,910	3,236	14,245		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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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						313,520	1
2	Skilled Nursing Care						1,453,109	2
3	Physical Therapy						759,582	3
4	Occupational Therapy						255,006	4
5	Speech Pathology						18,856	5
6	Medical Social Services							6
7	Home Health Aide						64,751	7
8	Supplies						48,504	8
9	Drugs						19,344	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)						2,932,672	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		313,520					1
2	Skilled Nursing Care		1,453,109	173,941	1,627,050			2
3	Physical Therapy		759,582	90,924	850,506			3
4	Occupational Therapy		255,006	30,525	285,531			4
5	Speech Pathology		18,856	2,257	21,113			5
6	Medical Social Services							6
7	Home Health Aide		64,751	7,751	72,502			7
8	Supplies		48,504	5,806	54,310			8
9	Drugs		19,344	2,316	21,660			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)		2,932,672	313,520	2,932,672			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.			0.119703				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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	7,914	203,682		151,849		1
2	Skilled Nursing Care			702,508		1,192,450		2
3	Physical Therapy			367,221		623,328		3
4	Occupational Therapy			123,283		209,263		4
5	Speech Pathology			9,116		15,474		5
6	Medical Social Services							6
7	Home Health Aide			31,304		53,136		7
8	Supplies					39,803		8
9	Drugs					15,874		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	7,914	1,437,114		2,301,177		20
21	Total cost to be allocated	63,006	8,522	566,717		503,017		21
22	Unit Cost Multiplier	18.774136		0.394344		0.218591		22
22	Unit Cost Multiplier		1.076826					22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	83,652		20,435				21
22	Unit Cost Multiplier	24.926103		6.089094				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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		31,607	12,605	1,990,095			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)		31,607	12,605	1,990,095			20
21	Total cost to be allocated		6,910	3,236	14,245			21
22	Unit Cost Multiplier			0.256724				22
22	Unit Cost Multiplier		0.218622		0.007158			22

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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**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	1,627,050		1,627,050	4,802	338.83	1
2	Physical Therapy	3	850,506		850,506	3,154	269.66	2
3	Occupational Therapy	4	285,531		285,531	952	299.93	3
4	Speech Pathology	5	21,113		21,113	117	180.45	4
5	Medical Social Services	6				1		5
6	Home Health Aide	7	72,502		72,502	675	107.41	6
7	Total (sum of lines 1-6)		2,856,702		2,856,702	9,701		7

Limitation Cost Computation						
			Program Visits			
			PART B			
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	27500		2,501		8
8.01	Skilled Nursing Care	40420		483		8.01
8.02	Skilled Nursing Care	99952		61		8.02
9	Physical Therapy	27500		1,563		9
9.01	Physical Therapy	40420		366		9.01
9.02	Physical Therapy	99952		12		9.02
10	Occupational Therapy	27500		538		10
10.01	Occupational Therapy	40420		87		10.01
10.02	Occupational Therapy	99952		6		10.02
11	Speech Pathology	27500		24		11
11.01	Speech Pathology	40420		20		11.01
11.02	Speech Pathology	99952				11.02
12	Medical Social Services	27500		1		12
12.01	Medical Social Services	40420				12.01
12.02	Medical Social Services	99952				12.02
13	Home Health Aide	27500		413		13
13.01	Home Health Aide	40420		51		13.01
13.02	Home Health Aide	99952				13.02
14	Total (sum of lines 8-13)			6,126		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	54,310		54,310			15
16	Cost of Drugs	9	21,660		21,660			16

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.300077			col. 2, line 2	1
2	Occupational Therapy	67	0.238297			col. 2, line 3	2

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

WORKSHEET H-3
PARTS I & II

Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX

3	Speech Pathology	68	0.383627			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.131698			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.257439			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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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

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		3,045			1,031,737		1,031,737
2	Physical Therapy		1,941			523,410		523,410
3	Occupational Therapy		631			189,256		189,256
4	Speech Pathology		44			7,940		7,940
5	Medical Social Services		1					
6	Home Health Aide		464			49,838		49,838
7	Total (sum of lines 1-6)		6,126			1,802,181		1,802,181

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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**HHA CCN: 52-7075****WORKSHEET H-4
PARTS I & II**Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX**PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES**

	Description	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	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	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		998,008	11
12	Total PPS Reimbursement - Full Episodes with Outliers		86,740	12
13	Total PPS Reimbursement - LUPA Episodes		25,835	13
14	Total PPS Reimbursement - PEP Episodes		10,101	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)		1,120,684	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,120,684	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,120,684	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)		1,120,684	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,120,684	31
31.01	Sequestration adjustment (see instructions)		22,412	31.01
31.02	Demonstration payment adjustment amount after sequestration		92	31.02
32	Interim payments (see instructions)		1,098,180	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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WORKSHEET H-5

(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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	782,947	Hours of Service	17,921.00	8.62	1
2	Licensed Practical Nurses	42,271	Hours of Service	1,694.00	0.81	2
3	Nurses Aides		Hours of Service			3
4	Technicians	491,680	Hours of Service	26,012.00	12.51	4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary	111,090	Accumulated Cost			8
9	Subtotal (sum of lines 1-8)	1,427,988				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	25,527	Percentage of Time			13
14	Supplies	1,054,568	Requisitions			14
15	Drugs	933,150	Requisitions			15
16	Other	110,253	Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*	3,551,486				17
18	Capital Related Costs-Bldgs. & Fixtures	132,489	Square Feet			18
19	Capital Related Costs-Mov. Equip.	29,046	Percentage of Time			19
20	Employee Benefits Department	563,118	Salary			20
21	Administrative and General	934,726	Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping	218,874	Square Feet			22
23	Medical Educatino Program Costs					23
24	Central Services & Supplies	172,388	Requisitions			24
25	Pharmacy	239,598	Requisitions			25
26	Other Allocated Costs	319,304	Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*	6,161,029				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)	6,161,029				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

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	351,363	54,573	782,947	533,951	563,118	1,172,748	1
	MAINTENANCE							
2	Hemodialysis	165,400	25,686	368,515	251,327	265,060	552,013	2
2.01	AKI - Hemodialysis							2.01
3	Intermittent Peritoneal							3
3.01	AKI - Intermittent Peritoneal							3.01
	TRAINING							
4	Hemodialysis							4
5	Intermittent Peritoneal							5
6	CAPD	50	6	87	50	56	117	6
7	CCPD	1,643	257	3,670	2,520	2,651	5,521	7
	HOME							
8	Hemodialysis							8
9	Intermittent Peritoneal							9
10	CAPD	4,630	722	10,354	7,056	7,446	15,507	10
11	CCPD	173,864	27,008	387,476	264,246	278,682	580,383	11
	OTHER BILLABLE SERVICES							
12	Inpatient Dialysis	5,776	894	12,845	8,752	9,223	19,207	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)	351,363	54,573	782,947	533,951	563,118	1,172,748	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: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	1,226,956		4,685,656	1,475,373	6,161,029	1
	MAINTENANCE						
2	Hemodialysis	577,528		2,205,529	694,455	2,899,984	2
2.01	AKI - Hemodialysis						2.01
3	Intermittent Peritoneal						3
3.01	AKI - Intermittent Peritoneal						3.01
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	123		489	154	643	6
7	CCPD	5,777		22,039	6,939	28,978	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	16,224		61,939	19,503	81,442	10
11	CCPD	607,209		2,318,868	730,142	3,049,010	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis	20,095		76,792	24,179	100,971	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)	1,226,956		4,685,656	1,475,373	6,161,029	17
18	Medical Educational Program Costs						18
19	Total Renal Costs (line 17 + line 18)					6,161,029	19

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	351,363	54,573	782,947	533,951	563,118	1
	MAINTENANCE						
2	Hemodialysis	3,322	12,697.00	8,435.00	14,961.00	672,154	2
2.01	AKI - Hemodialysis		0.00	0.00	0.00		2.01
3	Intermittent Peritoneal						3
3.01	AKI - Intermittent Peritoneal						3.01
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	1	3.00	2.00	3.00	143	6
7	CCPD	33	127.00	84.00	150.00	6,723	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	93	357.00	237.00	420.00	18,882	10
11	CCPD	3,492	13,350.00	8,869.00	15,730.00	706,699	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 327	116	442.00	294.00	521.00	23,387	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	26,976.00	17,921.00	31,785.00	1,427,988	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	49.789287	2.023020	43.688801	16.798836	0.394344	18

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	1,172,748	1,226,956				1
	MAINTENANCE						
2	Hemodialysis	439,234	371,180				2
2.01	AKI - Hemodialysis						2.01
3	Intermittent Peritoneal						3
3.01	AKI - Intermittent Peritoneal						3.01
	TRAINING						
4	Hemodialysis						4
5	Intermittent Peritoneal						5
6	CAPD	93	79				6
7	CCPD	4,393	3,713				7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	12,339	10,427				10
11	CCPD	461,808	390,256				11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 327	15,283	12,915				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	933,150	788,570			4,685,656	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	1.256763	1.555925			0.314870	18

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	9,398	2,899,984	308.57	6,623			2,043,659	1
2	Maintenance - Peritoneal Dialysis								2
3	Training - Hemodialysis								3
4	Training - Peritoneal Dialysis								4
5	Training - Continuous Ambulatory Peritoneal Dialysis	2	643	321.50	1			322	5
6	Training - Continuous Cycling Peritoneal Dialysis	94	28,978	308.28	29			8,940	6
7	Home Program - Hemodialysis	264							7
8	Home Program - Peritoneal Dialysis	9,881			5,997				8
		Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks		
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	52	81,442	1,566.19	52			81,442	9
10	Home Program - COntinuous Cycling Peritoneal Dialysis	1,568	3,049,010	1,944.52	948			1,843,405	10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	19,639	6,060,057		12,650			3,977,768	11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)	24,499							12

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	1,646,829			248.65			1
2	Maintenance - Peritoneal Dialysis							2
3	Training - Hemodialysis							3
4	Training - Peritoneal Dialysis							4
5	Training - Continuous Ambulatory Peritoneal Dialysis	304			304.00			5
6	Training - Continuous Cycling Peritoneal Dialysis	9,531			328.66			6
7	Home Program - Hemodialysis							7
8	Home Program - Peritoneal Dialysis	679,021			113.23			8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis							9
10	Home Program - Continuous Cycling Peritoneal Dialysis							10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	2,335,685						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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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B**WORKSHEET I-5**

	DESCRIPTION			
1	Total expenses related to care of program beneficiaries (see instructions)		3,977,768	1
		1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	2,335,685	2,335,685	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)	2,335,685	2,335,685	2.03
2.04	Outlier payments			2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)	549	549	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)	549	549	3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)	467,026	467,026	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)	467,026	467,026	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)		467,575	8
9	Program payment (see instructions)		1,868,109	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)		6,060,057	12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)		6,060,057	13
14	Facility specific composite cost percentage (line 13 divided by line 12)		1.000000	14

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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	1,271,877	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	59,488	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)	44.95	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)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	1,331,365	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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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice							116

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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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		
118	SUBTOTALS (sum of lines 1-117)							118
	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 CENTER							194.0 2
194.0 3	OCCUPATIONAL HEALTH AND WELLNESS							194.0 3
194.0 4	ASSISTED LIVING CENTERS							194.0 4
194.0 5	NORTHPOINTE FITNESS & SPA CENTER							194.0 5
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CCN: 52-1525
WORKSHEET O

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department		512,391	512,391		512,391		512,391	3
4	Administrative & General	320,824	42,350	363,174		363,174		363,174	4
5	Plant Operation & Maintenance		85,614	85,614	-98,365	-12,751		-12,751	5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies								10
11	Medical Records	38,482		38,482		38,482		38,482	11
12	Staff Transportation		69,451	69,451		69,451		69,451	12
13	Volunteer Service Coordination	37,242		37,242		37,242		37,242	13
14	Pharmacy		237,705	237,705		237,705		237,705	14
15	Physician Administrative Services								15
16	Other General Service		147,185	147,185		147,185		147,185	16
17	Patient/Residential Care Services								17
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	96,191		96,191		96,191		96,191	27
28	Registered Nurse	930,104		930,104		930,104		930,104	28
29	LPN/LVN	178		178		178		178	29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	150,658		150,658		150,658		150,658	33
34	Spiritual Counseling	111,261		111,261		111,261		111,261	34
35	Dietary Counseling								35
36	Counseling - Other	60,291		60,291		60,291		60,291	36
37	Hospice Aide and Homemaker Services	225,303		225,303		225,303		225,303	37
38	Durable Medical Equipment - Oxygen		18	18		18		18	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		627,427	627,427		627,427		627,427	41
42	Medical Supplies - Non-routine		367,263	367,263		367,263		367,263	42
42.5	Drugs Charged to Patients								42.5
0									0
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising	38,896		38,896		38,896		38,896	62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program	146,205	5,684	151,889		151,889		151,889	64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising	23,235	44,825	68,060		68,060	-44,825	23,235	67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
100	TOTAL	2,178,870	2,139,913	4,318,783	-98,365	4,220,418	-44,825	4,175,593	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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**ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CARE**
HOSPICE CCN: 52-1525
WORKSHEET O-1

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
42.5 0	Drugs Charged to Patients								42.5 0
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CARE
HOSPICE CCN: 52-1525**WORKSHEET O-2**

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner	96,191		96,191		96,191		96,191	27
28	Registered Nurse	930,104		930,104		930,104		930,104	28
29	LPN/LVN	178		178		178		178	29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	150,658		150,658		150,658		150,658	33
34	Spiritual Counseling	111,261		111,261		111,261		111,261	34
35	Dietary Counseling								35
36	Counseling - Other	60,291		60,291		60,291		60,291	36
37	Hospice Aide and Homemaker Services	225,303		225,303		225,303		225,303	37
38	Durable Medical Equipment - Oxygen		18	18		18		18	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		627,427	627,427		627,427		627,427	41
42	Medical Supplies - Non-routine		367,263	367,263		367,263		367,263	42
42.5 0	Drugs Charged to Patients								42.5 0
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1,573,986	994,708	2,568,694		2,568,694		2,568,694	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE
HOSPICE CCN: 52-1525**WORKSHEET O-3**

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
42.5 0	Drugs Charged to Patients								42.5 0
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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**ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE GENERAL INPATIENT CARE**
HOSPICE CCN: 52-1525
WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
42.5 0	Drugs Charged to Patients								42.5 0
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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**COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE
NET EXPENSES FOR ALLOCATION****HOSPICE CCN: 52-1525****WORKSHEET O-5**

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols 1+2)	
		1	2	3	
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt		75,096	75,096	1
2	Cap Rel Costs-Mvble Equip		30,410	30,410	2
3	Employee Benefits Department	512,391	859,224	1,371,615	3
4	Administrative & General	363,174	1,123,628	1,486,802	4
5	Plant Operation & Maintenance	-12,751	99,704	86,953	5
6	Laundry & Linen Service				6
7	Housekeeping		24,356	24,356	7
8	Dietary				8
9	Nursing Administration				9
10	Routine Medical Supplies		1,386	1,386	10
11	Medical Records	38,482	34,896	73,378	11
12	Staff Transportation	69,451		69,451	12
13	Volunteer Service Coordination	37,242		37,242	13
14	Pharmacy	237,705	60	237,765	14
15	Physician Administrative Services				15
16	Other General Service	147,185		147,185	16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care	2,568,694		2,568,694	51
52	Hospice Inpatient Respite Care				52
53	Hospice General Inpatient Care				53
	NONREIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising	38,896		38,896	62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program	151,889		151,889	64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising	23,235		23,235	67
68	Telehealth / Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	TOTAL	4,175,593	2,248,760	6,424,353	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS**HOSPICE CCN: 52-1525****WORKSHEET O-6
PART I**

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPART- MENT	SUBTOTAL	ADMINI- STRATIVE & GENERAL	PLANT OP & MAINT	
		0	1	2	3	3A	4	5	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	75,096	75,096						1
2	Cap Rel Costs-Mvble Equip	30,410		30,410					2
3	Employee Benefits Department	1,371,615			1,371,615				3
4	Administrative & General	1,486,802	75,096	30,410	201,961	1,794,269	1,794,269		4
5	Plant Operation & Maintenance	86,953				86,953	33,540	120,493	5
6	Laundry & Linen Service								6
7	Housekeeping	24,356				24,356	9,395		7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies	1,386				1,386	535		10
11	Medical Records	73,378			24,225	97,603	37,648		11
12	Staff Transportation	69,451				69,451	26,789		12
13	Volunteer Service Coordination	37,242				37,242	14,365		13
14	Pharmacy	237,765				237,765	91,712		14
15	Physician Administrative Services								15
16	Other General Service	147,185				147,185	56,773	120,493	16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care	2,568,694			990,836	3,559,530	1,373,001		51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program				23,444	23,444	9,043		61
62	Fundraising	38,896			24,485	63,381	24,448		62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program	151,889			92,037	243,926	94,088		64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising	23,235			14,627	37,862	22,932		67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL	6,424,353	75,096	30,410	1,371,615	6,424,353	1,794,269	120,493	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS**HOSPICE CCN: 52-1525****WORKSHEET O-6
PART I**

	Descriptions	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS- PORTATION	
		6	7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping		33,751						7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies					1,921			10
11	Medical Records						135,251		11
12	Staff Transportation							96,240	12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service		33,751						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care					1,921	135,251	96,240	51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL		33,751			1,921	135,251	96,240	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
HOSPICE CCN: 52-1525
**WORKSHEET O-6
PART I**

	Descriptions	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT/ RES CARE SVCS	TOTAL	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General							4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Routine Medical Supplies							10
11	Medical Records							11
12	Staff Transportation							12
13	Volunteer Service Coordination	51,607						13
14	Pharmacy		329,477					14
15	Physician Administrative Services							15
16	Other General Service				358,202			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care							50
51	Hospice Routine Home Care	51,607	329,477		358,202		5,905,229	51
52	Hospice Inpatient Respite Care							52
53	Hospice General Inpatient Care							53
	NONREIMBURSABLE COST CENTERS							
60	Bereavement Program							60
61	Volunteer Program						32,487	61
62	Fundraising						87,829	62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program						338,014	64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising						60,794	67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable							71
99	Negative Cost Center							99
100	TOTAL	51,607	329,477		358,202		6,424,353	100

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS
HOSPICE CCN: 52-1525
**WORKSHEET O-6
PART II**

	Descriptions	CAP REL BLDG & FIX SQUARE FEET	CAP REL MVBLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS DEPART- MENT GROSS SALARIES	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL ACCUM. COST	PLANT OP & MAINT SQUARE FEET	LAUNDRY & LINEN IN-FACIL- ITY DAYS	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	4,000							1
2	Cap Rel Costs-Mvble Equip		28,241						2
3	Employee Benefits Department			2,178,870					3
4	Administrative & General	4,000	28,241	320,824	-1,794,269	4,651,674			4
5	Plant Operation & Maintenance					86,953	4,000		5
6	Laundry & Linen Service								6
7	Housekeeping					24,356			7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies					1,386			10
11	Medical Records			38,482		97,603			11
12	Staff Transportation					69,451			12
13	Volunteer Service Coordination					37,242			13
14	Pharmacy					237,765			14
15	Physician Administrative Services								15
16	Other General Service					147,185	4,000		16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care			1,573,986		3,559,530			51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program			37,242		23,444			61
62	Fundraising			38,896		63,381			62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program			146,205		243,926			64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising			23,235	21,590	59,452			67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	75,096	30,410	1,371,615		1,794,269	120,493		100
101	Unit cost multiplier	18.774000	1.076803	0.629507		0.385725	30.123250		101

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS
HOSPICE CCN: 52-1525
**WORKSHEET O-6
PART II**

	Descriptions	HOUSE-KEEPING SQUARE FEET	DIETARY IN-FACIL-ITY DAYS	NURSING ADMINIS-TRATION DIRECT NURS. HRS.	ROUTINE MEDICAL SUPPLIES PATIENT DAYS	MEDICAL RECORDS PATIENT DAYS	STAFF TRANS-PORTATION MILEAGE	VOLUNTEER SVC COOR-DINATION HOURS OF SERVICE	
		7	8	9	10	11	12	13	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping	4,000							7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies				26,659				10
11	Medical Records					26,659			11
12	Staff Transportation						120,000		12
13	Volunteer Service Coordination							1,558	13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service	4,000							16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care				26,659	26,659	120,000	1,558	51
52	Hospice Inpatient Respite Care								52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	33,751			1,921	135,251	96,240	51,607	100
101	Unit cost multiplier	8.437750			0.072058	5.073371	0.802000	33.123877	101

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS**HOSPICE CCN: 52-1525****WORKSHEET O-6
PART II**

		PHARMACY	PHYSICIAN ADMIN SERVICES PATIENT DAYS	OTHER GENERAL SERVICE SPECIFY BASIS	PATIENT/ RESIDENT CARE SVCS IN-FACIL- ITY DAYS	
	Descriptions	CHARGES	14	15	16	17
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
3	Employee Benefits Department					3
4	Administrative & General					4
5	Plant Operation & Maintenance					5
6	Laundry & Linen Service					6
7	Housekeeping					7
8	Dietary					8
9	Nursing Administration					9
10	Routine Medical Supplies					10
11	Medical Records					11
12	Staff Transportation					12
13	Volunteer Service Coordination					13
14	Pharmacy	4,875,165				14
15	Physician Administrative Services					15
16	Other General Service			358,203		16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care					50
51	Hospice Routine Home Care	4,875,165		358,203		51
52	Hospice Inpatient Respite Care					52
53	Hospice General Inpatient Care					53
	NONREIMBURSABLE COST CENTERS					
60	Bereavement Program					60
61	Volunteer Program					61
62	Fundraising					62
63	Hospice/Palliative Medicine Fellows					63
64	Palliative care Program					64
65	Other Physician Services					65
66	Residential Care					66
67	Advertising					67
68	Telehealth / Telemonitoring					68
69	Thrift Store					69
70	Nursing Facility Room & Board					70
71	Other Nonreimbursable					71
99	Negative Cost Center					99
100	Cost to be allocated (per O-6 Pt I)	329,477		358,202		100
101	Unit cost multiplier	0.067583		0.999997		101

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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**APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED
SERVICE COSTS BY LEVEL OF CARE**
HOSPICE CCN: 52-1525**WORKSHEET O-7**

			Charges by LOC (from Provider Records)				
		Wkst C Pt I, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP
Cost Center Descriptions		0	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS							
1	Physical Therapy	66	0.300077				1
2	Occupational Therapy	67	0.238297				2
3	Speech Language Pathology	68	0.383627				3
4	Drugs, Biological & Infusion Therapy	73	0.257439				4
5	Durable Medical Equipment/Oxygen	96					5
6	Labs and Diagnostics	60	0.147488				6
7	Medical Supplies	71	0.131698				7
8	Outpatient Services (incl E/R)	93					8
9	Radiation Therapy	55	0.209980				9
10	Other	76					10
11	Totals (sum of lines 1-10)						11

		Shared Service Costs by LOC			
		HCHC (col 1 x col 2)	HRHC (col 1 x col 3)	HIRC (col 1 x col 4)	HGIP (col 1 x col 5)
Cost Center Descriptions		6	7	8	9
ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy				1
2	Occupational Therapy				2
3	Speech Language Pathology				3
4	Drugs, Biological & Infusion Therapy				4
5	Durable Medical Equipment/Oxygen				5
6	Labs and Diagnostics				6
7	Medical Supplies				7
8	Outpatient Services (incl E/R)				8
9	Radiation Therapy				9
10	Other				10
11	Totals (sum of lines 1-10)				11

KPMG LLP Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/23/2019 Run Time: 13:54 Version: 2018.12 (03/07/2019)
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CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST
HOSPICE CCN: 52-1525
WORKSHEET O-8

		TITLE XVIII MEDICARE 1	TITLE XIX MEDICAID 2	TOTAL 3	
	HOSPICE CONTINUOUS HOME CARE				
1	Total cost				1
2	Total unduplicated days				2
3	Total average cost per diem				3
4	Unduplicated program days				4
5	Program cost				5
	HOSPICE ROUTINE HOME CARE				
6	Total cost			5,905,229	6
7	Total unduplicated days			26,659	7
8	Total average cost per diem			221.51	8
9	Unduplicated program days	24,823	624		9
10	Program cost	5,498,543	138,222		10
	HOSPICE INPATIENT RESPITE CARE				
11	Total cost				11
12	Total unduplicated days				12
13	Total average cost per diem				13
14	Unduplicated program days				14
15	Program cost				15
	HOSPICE GENERAL INPATIENT CARE				
16	Total cost				16
17	Total unduplicated days				17
18	Total average cost per diem				18
19	Unduplicated program days				19
20	Program cost				20
	TOTAL HOSPICE CARE				
21	Total cost			5,905,229	21
22	Total unduplicated days			26,659	22
23	Average cost per diem			221.51	23