

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 prepared cost report 2. ☐ Manually prepared 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: 08/21/2020 Time: 11:32	
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 01/01/2019 and ending 12/31/2019, 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) SCOTT LECKEY
Chief Financial Officer or Administrator of Provider(s)

CEO
Title

08/21/2020 11:32
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		496,986	585,442		430,298	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		496,986	585,442		430,298	200

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
							V	XVIII	XIX
0		1	2	3	4	5	6	7	8
3	Hospital	BELOIT MEMORIAL HOSPITAL, INC.	52-0100	27500	1	07 / 01 / 1966	N	P	O
4	Subprovider - IPF								
5	Subprovider - IRF								
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA	AT HOME HEALTH CARE	52-7075	27500		09 / 01 / 1996	N	P	N
13	Separately Certified ASC								
14	Hospital-Based Hospice	BELOIT REGIONAL HOSPICE	52-1525	27500		01 / 01 / 2017			
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis	BELOIT MEMORIAL DIALYSIS	52-2324	27500		01 / 01 / 2004			
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2019	To: 12 / 31 / 2019	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.	676	227	150	41	2,029		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
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
		V	XVIII	
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	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

		1	2	3	
	Teaching Hospitals				
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter 'Y' for yes or 'N' for no in column 2.	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	NAHE MA Y/N 2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter 'Y' for yes or 'N' for no in column 2.	N			60
		1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
		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 and/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)								
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
		1	2	3	4	5		
65								65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)								
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
		1	2	3	4	5		
67								67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	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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WORKSHEET S-2 PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)					107
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter 'Y' for yes or 'N' for no in column 2. (see instructions)					
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
				Physical	Occupational	
				Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	2	3	
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.	N			111
		1	2	3	
112	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112

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. 15-1, 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:	359,535			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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Transplant Center Information

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

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		Title V	Title XIX	
		Part A	Part B	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)			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

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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

		Y/N			
Bed Complement					
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y		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	05/31/2020	Y	05/31/2020	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

Health Financial Systems Compu-Max 2552-10

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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	
	1	2	
Home Office Costs			
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	

Health Financial Systems Compu-Max 2552-10

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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	Hospital 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	79	28,835			6,457	476	13,921
2	HMO and other (see instructions)						3,612	2,447	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)		79	28,835			6,457	476	13,921
8	Intensive Care Unit	31	18	6,570			1,055	40	1,984
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						160	908
14	Total (see instructions)		97	35,405			7,512	676	16,813
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					4,612	528	7,807
23	ASC (Distinct Part)	115							23
24	Hospice (Distinct Part)	116		22,811			21,293	95	22,811
24.10	Hospice (non-distinct part)	30							24.10
25	CMHC	99							25
26	RHC	88							26
27	Total (sum of lines 14-26)		97						27
28	Observation Bed Days							48	1,246
29	Ambulance Trips								29
30	Employee discount days (see instructions)								30
31	Employee discount days-IRF								31
32	Labor & delivery (see instructions)								6
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

Health Financial Systems Compu-Max 2552-10

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,646	144	4,065	1
2	HMO and other (see instructions)					728	590		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)		1,250.00			1,646	144	4,065	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		17.00						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		36.00						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		1,303.00						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

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassi- fication 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	101,735,663		101,735,663	2,709,986.00	37.54	1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B		140,026		140,026	3,479.00	40.25	3
4 Physician-Part A - Administrative		268,050		268,050	1,415.00	189.43	4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B		24,220,207		24,220,207	123,854.00	195.55	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)		7,628,048		7,628,048	275,809.00	27.66	10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		485,854		485,854	5,507.00	88.22	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
16.01 Home office Physicians Part A - Teaching							16.01
16.02 Home office contract Physicians Part A - Teaching							16.02
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		33,488,330		33,488,330			17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		3,901,493		3,901,493			19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B		55,928		55,928			21
22 Physician Part A - Administrative		38,485		38,485			22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B		3,476,197		3,476,197			23
24 Wage-related costs (RHC/FOHC)							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: Physicians Part A - Teaching - wage-related (core)							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department							26
27 Administrative & General		10,382,777		10,382,777	379,716.00	27.34	27
28 Administrative & General under contract (see instructions)		197,336		197,336	852.00	231.62	28
29 Maintenance & Repairs							29
30 Operation of Plant		1,953,058		1,953,058	69,894.00	27.94	30
31 Laundry & Linen Service		60,272		60,272	4,582.00	13.15	31
32 Housekeeping		1,399,663		1,399,663	102,353.00	13.67	32
33 Housekeeping under contract (see instructions)							33
34 Dietary		1,006,828		1,006,828	59,615.00	16.89	34
35 Dietary under contract (see instructions)							35
36 Cafeteria		105,410		105,410	8,852.00	11.91	36
37 Maintenance of Personnel							37
38 Nursing Administration		1,196,143		1,196,143	37,272.00	32.09	38
39 Central Services and Supply		602,783		602,783	27,658.00	21.79	39
40 Pharmacy		1,872,037		1,872,037	45,180.00	41.44	40
41 Medical Records & Medical Records Library		2,453,820		2,453,820	111,714.00	21.97	41
42 Social Service		651,797		651,797	19,259.00	33.84	42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		77,572,766		77,572,766	2,583,505.00	30.03	1
2	Excluded area salaries (see instructions)		7,628,048		7,628,048	275,809.00	27.66	2
3	Subtotal salaries (line 1 minus line 2)		69,944,718		69,944,718	2,307,696.00	30.31	3
4	Subtotal other wages & related costs (see instructions)		485,854		485,854	5,507.00	88.22	4
5	Subtotal wage-related costs (see instructions)		33,526,815		33,526,815		47.93%	5
6	Total (sum of lines 3 through 5)		103,957,387		103,957,387	2,313,203.00	44.94	6
7	Total overhead cost (see instructions)		21,881,924		21,881,924	866,947.00	25.24	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	3,716,074	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	3,613,920	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)	25,159,462	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	510,312	10
11	Life Insurance (If employee is owner or beneficiary)	69,264	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	325,439	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	624,619	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	6,327,372	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	45,551	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	568,420	23
24	Total Wage Related cost (Sum of lines 1-23)	40,960,433	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

Health Financial Systems Compu-Max 2552-10

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**HHA CCN: 52-7075****WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		140	16	81	237	1
2	Unduplicated Census Count (see instructions)		298.00				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	8.00		8.00	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				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	4	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	27500	20
20.01		31540	20.01
20.02		40420	20.02
20.03		99952	20.03

PPS ACTIVITY

		Full Episodes					
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4	Total (columns 1 through 4) 5	
21	Skilled Nursing Visits	1,617	375	88	7	2,087	21
22	Skilled Nursing Visit Charges	648,612	150,245	35,341	2,826	837,024	22
23	Physical Therapy Visits	1,503	98	54	6	1,661	23
24	Physical Therapy Visit Charges	656,811	42,826	23,598	2,622	725,857	24
25	Occupational Therapy Visits	474	34	11	4	523	25
26	Occupational Therapy Visit Charges	207,138	14,858	4,807	1,783	228,586	26
27	Speech Pathology Visits	42	16			58	27
28	Speech Pathology Visit Charges	18,354	6,992			25,346	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	110	23	2	3	138	31
32	Home Health Aide Visit Charges	21,108	4,370	396	570	26,444	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,746	546	155	20	4,467	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,552,023	219,291	64,142	7,801	1,843,257	35
36	Total Number of Episodes (standard/non-outlier)	287		51	3	341	36
37	Total Number of Ourlier Episodes		16			16	37
38	Total Non-Routine Medical Supply Charges	82,471	4,117	639		87,227	38

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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	70					30	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	313						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	6	11
12	Number of patients transplanted during the cost reporting period	4	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

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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	21,293	95	1,423	22,811	11
12	Hospice Inpatient Respite Care					12
13	Hospice General Inpatient Care					13
14	Total Hospice Days	21,293	95	1,423	22,811	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.

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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)	0.216196	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	16,742,881	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	110,587,061	6
7	Medicaid cost (line 1 times line 6)	23,908,480	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	7,165,599	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)	7,165,599	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)	93,395	103,696	197,091	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	20,192	103,696	123,888	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)	20,192	103,696	123,888	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)			16,795,971	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			719,011	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,106,171	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			15,689,800	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			3,779,232	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			3,903,120	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			11,068,719	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		8,315,752	8,315,752	4,270,001	12,585,753	-936,371	11,649,382	1
2	00200	Cap Rel Costs-Mvble Equip		4,108,351	4,108,351	1,089,577	5,197,928		5,197,928	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		36,482,667	36,482,667		36,482,667	-14,072,391	22,410,276	4
5	00500	Administrative & General	10,382,777	23,790,728	34,173,505	-693,109	33,480,396	-9,743,307	23,737,089	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,953,058	6,138,148	8,091,206	-28,645	8,062,561	-684,057	7,378,504	7
8	00800	Laundry & Linen Service	60,272	584,076	644,348	-27	644,321	-26,941	617,380	8
9	00900	Housekeeping	1,399,663	507,702	1,907,365		1,907,365	-275,023	1,632,342	9
10	01000	Dietary	1,006,828	471,668	1,478,496		1,478,496	-12,976	1,465,520	10
11	01100	Cafeteria	105,410	553,600	659,010		659,010	-495,278	163,732	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,196,143	85,486	1,281,629		1,281,629	-389,608	892,021	13
14	01400	Central Services & Supply	602,783	553,943	1,156,726	-180,951	975,775	-60	975,715	14
15	01500	Pharmacy	1,872,037	175,217	2,047,254		2,047,254		2,047,254	15
16	01600	Medical Records & Library	2,453,820	404,854	2,858,674		2,858,674	-624,345	2,234,329	16
17	01700	Social Service	651,797	18,897	670,694		670,694		670,694	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	8,008,171	448,571	8,456,742	-18,304	8,438,438	-8,963	8,429,475	30
31	03100	Intensive Care Unit	2,022,964	284,059	2,307,023	-2,282	2,304,741	-9	2,304,732	31
43	04300	Nursery	190,913		190,913		190,913		190,913	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,147,562	949,257	3,096,819	-42,514	3,054,305		3,054,305	50
51	05100	Recovery Room	342,666	18,121	360,787		360,787		360,787	51
52	05200	Delivery Room & Labor Room	471,668		471,668		471,668		471,668	52
53	05300	Anesthesiology	140,026	336,292	476,318		476,318	-140,026	336,292	53
54	05400	Radiology-Diagnostic	1,505,102	691,640	2,196,742		2,196,742	-312,713	1,884,029	54
55	05500	Radiology-Therapeutic	397,932	582,705	980,637		980,637	-504	980,133	55
57	05700	CT Scan	821,865	404,797	1,226,662		1,226,662		1,226,662	57
58	05800	MRI	391,604	360,320	751,924	-35,597	716,327		716,327	58
59	05900	Cardiac Catheterization	1,764,675	1,053,447	2,818,122	-12,900	2,805,222		2,805,222	59
60	06000	Laboratory	3,197,307	5,320,366	8,517,673		8,517,673	-15,341	8,502,332	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	933,568	320,223	1,253,791	-3,304	1,250,487		1,250,487	65
66	06600	Physical Therapy	2,520,645	158,844	2,679,489	-21,550	2,657,939	-1,408,036	1,249,903	66
67	06700	Occupational Therapy	218,660	1,360	220,020		220,020	-24,662	195,358	67
68	06800	Speech Pathology	161,030	-18,447	142,583		142,583		142,583	68
69	06900	Electrocardiology	303,190	46,729	349,919		349,919	-34,195	315,724	69
71	07100	Medical Supplies Charged to Patients		13,236,444	13,236,444		13,236,444	-1,213,153	12,023,291	71
73	07300	Drugs Charged to Patients		21,343,971	21,343,971		21,343,971	-5,440,273	15,903,698	73
74	07400	Renal Dialysis	1,655,453	2,979,963	4,635,416		4,635,416		4,635,416	74
75	07500	ASC (Non-Distinct Part)	869,304	467,938	1,337,242	-200	1,337,042		1,337,042	75
76	03950	OTHER ANCILLARY								76
76.01	03280	SLEEP/EEG	282,727	269,396	552,123	-817	551,306		551,306	76.01
76.02	03340	GI	743,800	278,321	1,022,121	-47,132	974,989		974,989	76.02
76.03	03450	NUCLEAR MED	258,789	173,475	432,264		432,264		432,264	76.03
76.04	03550	PSYCH	1,724,719	520,611	2,245,330	-5,962	2,239,368	-85,486	2,153,882	76.04
76.05	03630	ULTRASOUND	456,036	104,363	560,399		560,399	-76,020	484,379	76.05
76.06	03650	VASCULAR LAB	569,054	92,481	661,535		661,535		661,535	76.06
76.07	03951	MEDICAL OUTPATIENT	399,624	24,485	424,109		424,109		424,109	76.07
76.97	07697	CARDIAC REHABILITATION	236,018	3,773	239,791		239,791	-12	239,779	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY		320,556	320,556	-500	320,056		320,056	76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	35,390,146	5,607,710	40,997,856		40,997,856	-40,997,856		90
91	09100	Emergency	4,297,809	1,040,541	5,338,350		5,338,350	-1,953	5,336,397	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	1,400,330	755,040	2,155,370		2,155,370	-7,910	2,147,460	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		4,150,778	4,150,778	-4,150,778				113
116	11600	Hospice	2,207,770	1,557,544	3,765,314	-95,430	3,669,884	-269,705	3,400,179	116
118		SUBTOTALS (sum of lines 1-117)	97,715,715	146,076,763	243,792,478	19,576	243,812,054	-77,297,174	166,514,880	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	54,012	65,937	119,949		119,949		119,949	190

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194	07950	PATHOLOGY	38,352	5,612	43,964		43,964		43,964	194
194.01	07951	PHYSIATRY CLINIC	416,186	2,562	418,748		418,748		418,748	194.01
194.02	07952	JANESVILLE MED CENTER	160,855	57,550	218,405	-17,340	201,065		201,065	194.02
194.03	07953	OCCUPATIONAL HEALTH AND WELLNESS	1,475,642	215,912	1,691,554		1,691,554		1,691,554	194.03
194.04	07954	ASSISTED LIVING CENTERS	1,610,785	967,192	2,577,977	-2,236	2,575,741		2,575,741	194.04
194.05	07955	NORTHPOINTE FITNESS & SPA CENTER	264,116	2,161,984	2,426,100		2,426,100		2,426,100	194.05
200		TOTAL (sum of lines 118-199)	101,735,663	149,553,512	251,289,175		251,289,175	-77,297,174	173,992,001	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Bldg & Fixt	1		3,690,802	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Cap Rel Costs-Mvble Equip	2		459,976	2
500	Total reclassifications					4,150,778	500
	Code Letter - A						
1	RENTS & LEASES	B	Cap Rel Costs-Bldg & Fixt	1		579,199	1
2	RENTS & LEASES	B	Cap Rel Costs-Mvble Equip	2		629,601	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
500	Total reclassifications					1,208,800	500
	Code Letter - B						
	GRAND TOTAL (Increases)					5,359,578	

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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	RECLASS INTEREST EXPENSE TO CAPITAL	A	Interest Expense	113		3,690,802	11	1
2	RECLASS INTEREST EXPENSE TO CAPITAL	A	Interest Expense	113		459,976	11	2
500	Total reclassifications					4,150,778		500
	Code letter - A							
1	RENTS & LEASES	B	Administrative & General	5		693,109	10	1
2	RENTS & LEASES	B	Operation of Plant	7		28,645	10	2
3			Laundry & Linen Service	8		27	10	3
4			Central Services & Supply	14		180,951	10	4
5			Adults & Pediatrics	30		18,304	10	5
6			Intensive Care Unit	31		2,282	10	6
7			Operating Room	50		42,514	10	7
8			MRI	58		35,597	10	8
9			Cardiac Catheterization	59		12,900	10	9
10			Respiratory Therapy	65		3,304	10	10
11			Physical Therapy	66		21,550	10	11
12			ASC (Non-Distinct Part)	75		200	10	12
13			SLEEP/EEG	76.01		817	10	13
14			GI	76.02		47,132	10	14
15			PSYCH	76.04		5,962	10	15
16			LITHOTRIPSY	76.99		500	10	16
17			Hospice	116		95,430	10	17
18			JANESVILLE MED CENTER	194.02		17,340	10	18
19			ASSISTED LIVING CENTERS	194.04		2,236	10	19
500	Total reclassifications					1,208,800		500
	Code letter - B							
	GRAND TOTAL (Decreases)					5,359,578		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	8,100,877					8,100,877		1
2	Land Improvements	7,699,872	406,436		406,436	747,867	7,358,441	2,863,778	2
3	Buildings and Fixtures	144,126,526	2,652,924		2,652,924	373,339	146,406,111	23,091,879	3
4	Building Improvements								4
5	Fixed Equipment	40,816,172	1,146,150		1,146,150		41,962,322	11,017,299	5
6	Movable Equipment	59,868,011	3,826,792		3,826,792	556,957	63,137,846	35,409,521	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	260,611,458	8,032,302		8,032,302	1,678,163	266,965,597	72,382,477	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	260,611,458	8,032,302		8,032,302	1,678,163	266,965,597	72,382,477	10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	8,315,752						8,315,752	1
2	Cap Rel Costs-Mvble Equip	4,108,351						4,108,351	2
3	Total (sum of lines 1-2)	12,424,103						12,424,103	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	203,827,751		203,827,751	0.763498					1
2	Cap Rel Costs-Mvble Equip	63,137,846		63,137,846	0.236502					2
3	Total (sum of lines 1-2)	266,965,597		266,965,597	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	7,379,381	579,199	3,690,802				11,649,382	1
2	Cap Rel Costs-Mvble Equip	4,108,351	629,601	459,976				5,197,928	2
3	Total (sum of lines 1-2)	11,487,732	1,208,800	4,150,778				16,847,310	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE#	Wkst. A-7 Ref.	
DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER			
	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	-71,181	Operation of Plant	7		8
9 Parking lot (chapter 21)						9
10 Provider-based physician adjustment	Wkst A-8-2	-24,345,472				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	-52,090	Employee Benefits Department	4		33
34 CRNA OFFSET	A	-140,026	Anesthesiology	53		34
35 PATIENT PORTION OF OPERATORS TIME	A	-1,742	Employee Benefits Department	4		35
36 PATIENT PORTION OF OPERATORS TIME	A	-4,682	Administrative & General	5		36
37 ADVERTISING OFFSET	A	-886,568	Administrative & General	5		37
38 ADVERTISING OFFSET	A	-3,677	Operation of Plant	7		38
39 ADVERTISING OFFSET	A	-12,976	Dietary	10		39
40 ADVERTISING OFFSET	A	-60	Central Services & Supply	14		40
41 ADVERTISING OFFSET	A	-8,887	Adults & Pediatrics	30		41
42 ADVERTISING OFFSET	A	-9	Intensive Care Unit	31		42
43 ADVERTISING OFFSET	A	-504	Radiology-Therapeutic	55		43
44 ADVERTISING OFFSET	A	-2,281	Laboratory	60		44
45 ADVERTISING OFFSET	A	-6,723	Physical Therapy	66		45
46 ADVERTISING OFFSET	A	-5,139	PSYCH	76.04		46
47 ADVERTISING OFFSET	A	-1,953	Emergency	91		47
48 ADVERTISING OFFSET	A	-7,188	Home Health Agency	101		48
49 ADVERTISING OFFSET	A	-32,377	Hospice	116		49
49.01 MISC REV OFFSET	B	-1,085,263	Administrative & General	5		49.01
49.02 MISC REV OFFSET	B	-1,010	Operation of Plant	7		49.02
49.03 MISC REV OFFSET	B	-5,880	Housekeeping	9		49.03
49.04 MISC REV OFFSET	B	-495,278	Cafeteria	11		49.04
49.05 MISC REV OFFSET	B	-1,896	Medical Records & Library	16		49.05
49.06 MISC REV OFFSET	B	-76	Adults & Pediatrics	30		49.06
49.07 MISC REV OFFSET	B	-339	Physical Therapy	66		49.07
49.08 MISC REV OFFSET	B	-80,347	PSYCH	76.04		49.08
49.09 MISC REV OFFSET	B	-12	CARDIAC REHABILITATION	76.97		49.09
49.10 MISC REV OFFSET	B	-722	Home Health Agency	101		49.10
49.11 MISC REV OFFSET	B	-237,328	Hospice	116		49.11
49.12 REMOVE EST OF CLINIC COSTS	A	-936,371	Cap Rel Costs-Bldg & Fixt	1	9	49.12
49.13 REMOVE EST OF CLINIC COSTS	A	-14,018,559	Employee Benefits Department	4		49.13
49.14 REMOVE EST OF CLINIC COSTS	A	-7,766,794	Administrative & General	5		49.14
49.15 REMOVE EST OF CLINIC COSTS	A	-608,189	Operation of Plant	7		49.15
49.16 REMOVE EST OF CLINIC COSTS	A	-26,941	Laundry & Linen Service	8		49.16

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
49.17	REMOVE EST OF CLINIC COSTS	A	-269,143	Housekeeping	9		49.17
49.18	REMOVE EST OF CLINIC COSTS	A	-389,608	Nursing Administration	13		49.18
49.19	REMOVE EST OF CLINIC COSTS	A	-622,449	Medical Records & Library	16		49.19
49.20	REMOVE EST OF CLINIC COSTS	A	-312,713	Radiology-Diagnostic	54		49.20
49.21	REMOVE EST OF CLINIC COSTS	A	-13,060	Laboratory	60		49.21
49.22	REMOVE EST OF CLINIC COSTS	A	-1,400,974	Physical Therapy	66		49.22
49.23	REMOVE EST OF CLINIC COSTS	A	-24,662	Occupational Therapy	67		49.23
49.24	REMOVE EST OF CLINIC COSTS	A	-34,195	Electrocardiology	69		49.24
49.25	REMOVE EST OF CLINIC COSTS	A	-1,213,153	Medical Supplies Charged to Patients	71		49.25
49.26	REMOVE EST OF CLINIC COSTS	A	-5,440,273	Drugs Charged to Patients	73		49.26
49.27	REMOVE EST OF CLINIC COSTS	A	-76,020	ULTRASOUND	76.05		49.27
49.28	REMOVE EST OF CLINIC COSTS	A	-16,652,384	Clinic	90		49.28
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-77,297,174				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	90	Clinic FAMILY PRACTICE	3,563,947	3,468,947	95,000	179,000	599	51,549	2,577	1
2	90	Clinic INTERNAL MEDICI	1,547,136	1,537,536	9,600	197,500	66	6,267	313	2
3	90	Clinic SURGERY	3,725,914	3,704,914	21,000	246,400	87	10,306	515	3
4	90	Clinic PEDIATRICS	1,023,811	1,023,811		169,700				4
5	90	Clinic OB/GYN	1,830,510	1,818,510	12,000	237,100	71	8,093	405	5
6	90	Clinic ALL OTHERS	12,796,939	12,666,489	130,450	211,500	592	60,196	3,010	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	24,488,257	24,220,207	268,050		1,415	136,411	6,820	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	90	Clinic FAMILY PRACTICE	47,200	1,258	22,370	596	53,403	41,597	3,510,544	1
2	90	Clinic INTERNAL MEDICI	19,526	121	12,989	81	6,469	3,131	1,540,667	2
3	90	Clinic SURGERY	41,871	236	62,215	351	10,893	10,107	3,715,021	3
4	90	Clinic PEDIATRICS	7,943		10,173				1,023,811	4
5	90	Clinic OB/GYN	16,013	105	38,748	254	8,452	3,548	1,822,058	5
6	90	Clinic ALL OTHERS	117,760	1,200	213,040	2,172	63,568	66,882	12,733,371	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	250,313	2,920	359,535	3,454	142,785	125,265	24,345,472	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	11,649,382	11,649,382					1
2	Cap Rel Costs-Mvble Equip	5,197,928		5,197,928				2
4	Employee Benefits Department	22,410,276			22,410,276			4
5	Administrative & General	23,737,089	3,080,085	761,810	3,507,123	31,086,107	31,086,107	5
6	Maintenance & Repairs							6
7	Operation of Plant	7,378,504	617,910	84,391	659,706	8,740,511	1,901,315	7
8	Laundry & Linen Service	617,380	29,418	31	20,359	667,188	145,133	8
9	Housekeeping	1,632,342	8,613	694	472,780	2,114,429	459,950	9
10	Dietary	1,465,520	88,254	6,422	340,087	1,900,283	413,367	10
11	Cafeteria	163,732	81,855	2,623	35,605	283,815	61,738	11
12	Maintenance of Personnel							12
13	Nursing Administration	892,021	34,226	189,728	404,034	1,520,009	330,646	13
14	Central Services & Supply	975,715	151,311	270,664	203,609	1,601,299	348,329	14
15	Pharmacy	2,047,254	50,204	170,612	632,339	2,900,409	630,923	15
16	Medical Records & Library	2,234,329	193,053	120	828,854	3,256,356	708,352	16
17	Social Service	670,694	9,371		220,165	900,230	195,826	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	8,429,475	796,670	118,781	2,705,008	12,049,934	2,621,210	30
31	Intensive Care Unit	2,304,732	68,055	145,009	683,319	3,201,115	696,335	31
43	Nursery	190,913			64,487	255,400	55,557	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,054,305	221,543	332,065	725,406	4,333,319	942,623	50
51	Recovery Room	360,787	24,193		115,746	500,726	108,922	51
52	Delivery Room & Labor Room	471,668			159,320	630,988	137,258	52
53	Anesthesiology	336,292	9,181	13,629	47,298	406,400	88,404	53
54	Radiology-Diagnostic	1,884,029	261,562	206,497	508,395	2,860,483	622,238	54
55	Radiology-Therapeutic	980,133	128,462	94,072	134,414	1,337,081	290,854	55
57	CT Scan	1,226,662	25,140	142,042	277,610	1,671,454	363,590	57
58	MRI	716,327	17,946	138,601	132,276	1,005,150	218,649	58
59	Cardiac Catheterization	2,805,222	76,157	729,299	596,074	4,206,752	915,091	59
60	Laboratory	8,502,332	282,405	183,781	1,079,990	10,048,508	2,185,842	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,250,487	47,137	79,732	315,342	1,692,698	368,211	65
66	Physical Therapy	1,249,903	298,855	23,497	851,426	2,423,681	527,221	66
67	Occupational Therapy	195,358	15,069		73,859	284,286	61,840	67
68	Speech Pathology	142,583	8,613		54,393	205,589	44,722	68
69	Electrocardiology	315,724	9,276	9,018	102,412	436,430	94,936	69
71	Medical Supplies Charged to Patients	12,023,291				12,023,291	2,615,414	71
73	Drugs Charged to Patients	15,903,698				15,903,698	3,459,445	73
74	Renal Dialysis	4,635,416	133,592	20,003	559,181	5,348,192	1,163,387	74
75	ASC (Non-Distinct Part)	1,337,042	734,768	558,989	293,634	2,924,433	636,149	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	551,306	12,797	12,561	95,500	672,164	146,215	76.01
76.02	GI	974,989	58,438	277,305	251,242	1,561,974	339,775	76.02
76.03	NUCLEAR MED	432,264	14,785	60,863	87,414	595,326	129,501	76.03
76.04	PSYCH	2,153,882	119,035	1,639	582,577	2,857,133	621,509	76.04
76.05	ULTRASOUND	484,379	29,475	50,620	154,040	718,514	156,298	76.05
76.06	VASCULAR LAB	661,535	37,785	15,700	192,216	907,236	197,350	76.06
76.07	MEDICAL OUTPATIENT	424,109	18,930	562	134,985	578,586	125,859	76.07
76.97	CARDIAC REHABILITATION	239,779	31,860	1,483	79,722	352,844	76,754	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	320,056		581		320,637	69,748	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	5,336,397	498,156	394,279	1,451,718	7,680,550	1,670,742	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2,147,460	63,531	9,189	473,005	2,693,185	585,846	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	3,400,179	75,722	17,293	745,743	4,238,937	922,092	116
118	SUBTOTALS (sum of lines 1-117)	166,514,880	8,463,438	5,124,185	21,052,413	161,897,330	28,455,166	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	119,949	22,187	2,918	18,244	163,298	35,522	190
194	PATHOLOGY	43,964	9,825	5,400	12,955	72,144	15,693	194
194.01	PHYSIATRY CLINIC	418,748	12,759		140,580	572,087	124,446	194.01

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
194.02	JANESVILLE MED CENTER	201,065	95,164	2,475	54,334	353,038	76,796	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	1,691,554	165,206	9,759	498,444	2,364,963	514,448	194.03
194.04	ASSISTED LIVING CENTERS	2,575,741	1,801,860	18,407	544,093	4,940,101	1,074,615	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	2,426,100	1,078,943	34,784	89,213	3,629,040	789,421	194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,992,001	11,649,382	5,197,928	22,410,276	173,992,001	31,086,107	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	10,641,826						7
8	Laundry & Linen Service	39,372	851,693					8
9	Housekeeping	11,528		2,585,907				9
10	Dietary	118,116		28,839	2,460,605			10
11	Cafeteria	109,552		26,749		481,854		11
12	Maintenance of Personnel							12
13	Nursing Administration	45,807		11,184		13,222	1,920,868	13
14	Central Services & Supply	202,509		49,445		9,549		14
15	Pharmacy	67,191		16,405		16,160		15
16	Medical Records & Library	258,375		63,085		39,665		16
17	Social Service	12,541		3,062		6,611		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	1,066,232	378,207	260,334	2,159,647	96,222	764,843	30
31	Intensive Care Unit	91,082	47,640	22,239	300,958	20,567	163,478	31
43	Nursery					2,204	17,516	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	296,505	124,384	72,395		22,036	175,155	50
51	Recovery Room	32,379		7,906		2,938	23,354	51
52	Delivery Room & Labor Room					4,407	35,031	52
53	Anesthesiology	12,288		3,000		1,469	11,677	53
54	Radiology-Diagnostic	350,065	70,617	85,473		19,098		54
55	Radiology-Therapeutic	171,929		41,979		3,673		55
57	CT Scan	33,646		8,215		8,080		57
58	MRI	24,018		5,864		3,673		58
59	Cardiac Catheterization	101,926		24,886		14,691		59
60	Laboratory	377,960		92,284		43,337		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	63,086		15,403		10,283		65
66	Physical Therapy	399,976	19,607	97,659		22,771		66
67	Occupational Therapy	20,167		4,924		1,469		67
68	Speech Pathology	11,528		2,815		1,469		68
69	Electrocardiology	12,415		3,031		5,142		69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	178,795	31,556	43,655		19,098	151,801	74
75	ASC (Non-Distinct Part)	983,384	26,347	240,106		8,814	70,062	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	17,127		4,182		2,938	23,354	76.01
76.02	GI	78,212		19,096		8,814	70,062	76.02
76.03	NUCLEAR MED	19,787		4,831		2,204		76.03
76.04	PSYCH	159,312		38,898		14,691		76.04
76.05	ULTRASOUND	39,448		9,632		4,407		76.05
76.06	VASCULAR LAB	50,570	10,263	12,347		4,407	35,031	76.06
76.07	MEDICAL OUTPATIENT	25,336		6,186		3,673	29,193	76.07
76.97	CARDIAC REHABILITATION	42,640		10,411		2,204	17,516	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	666,712	143,072	162,786		41,868	332,795	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	85,027		20,760				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	101,343		24,744				116
118	SUBTOTALS (sum of lines 1-117)	6,377,886	851,693	1,544,810	2,460,605	481,854	1,920,868	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	29,694		7,250				190
194	PATHOLOGY	13,149		3,211				194
194.01	PHYSIATRY CLINIC	17,076		4,169				194.01
194.02	JANESVILLE MED CENTER	127,363		31,097				194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	221,106		53,986				194.03

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
194.04	ASSISTED LIVING CENTERS	2,411,537		588,810				194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	1,444,015		352,574				194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,641,826	851,693	2,585,907	2,460,605	481,854	1,920,868	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	2,211,131						14
15	Pharmacy	10,738	3,641,826					15
16	Medical Records & Library	4		4,325,837				16
17	Social Service		4		1,118,274			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	87,916	2,421	167,513	1,118,274	20,772,753		30
31	Intensive Care Unit	26,718	3,134	65,792		4,639,058		31
43	Nursery			10,831		341,508		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,114,526	26,942	184,606		7,292,491		50
51	Recovery Room	10,464	654	32,087		719,430		51
52	Delivery Room & Labor Room			28,208		835,892		52
53	Anesthesiology	25,334	17,739	35,987		602,298		53
54	Radiology-Diagnostic	4,196	1,052	114,161		4,127,383		54
55	Radiology-Therapeutic	739		114,084		1,960,339		55
57	CT Scan	7,389	771	329,717		2,422,862		57
58	MRI	472	1,505	112,550		1,371,881		58
59	Cardiac Catheterization	278,982	18,366	146,601		5,707,295		59
60	Laboratory	16,686	257	590,916		13,355,790		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,820		33,079		2,197,580		65
66	Physical Therapy	31,349	77	81,861		3,604,202		66
67	Occupational Therapy	640	4	12,532		385,862		67
68	Speech Pathology	1,876	2	5,496		273,497		68
69	Electrocardiology	2,443		100,098		654,495		69
71	Medical Supplies Charged to Patients			718,645		15,357,350		71
73	Drugs Charged to Patients		3,245,211	585,177		23,193,531		73
74	Renal Dialysis	162,046	202,092	118,011		7,418,633		74
75	ASC (Non-Distinct Part)	190,714	7,945	46,529		5,134,483		75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	17		15,733		881,730		76.01
76.02	GI	108,695	8,441	153,836		2,348,905		76.02
76.03	NUCLEAR MED	108	88,309	55,994		896,060		76.03
76.04	PSYCH	85		20,384		3,712,012		76.04
76.05	ULTRASOUND	2,690	364	58,601		989,954		76.05
76.06	VASCULAR LAB	579		36,255		1,254,038		76.06
76.07	MEDICAL OUTPATIENT	11,555	827	6,387		787,602		76.07
76.97	CARDIAC REHABILITATION	244		6,682		509,295		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY			20,407		410,792		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	89,435	1,611	280,533		11,070,104		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	4,384	3,463	10,427		3,403,092		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	4,506	412	26,117		5,318,151		116
118	SUBTOTALS (sum of lines 1-117)	2,210,350	3,631,603	4,325,837	1,118,274	153,950,348		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					235,764		190
194	PATHOLOGY	16				104,213		194
194.01	PHYSIATRY CLINIC		5			717,783		194.01
194.02	JANESVILLE MED CENTER	55	763			589,112		194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	330	9,294			3,164,127		194.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	
		14	15	16	17	24	25	
194.04	ASSISTED LIVING CENTERS	356	153			9,015,572		194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	24	8			6,215,082		194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,211,131	3,641,826	4,325,837	1,118,274	173,992,001		202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	20,772,753					30
31	Intensive Care Unit	4,639,058					31
43	Nursery	341,508					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,292,491					50
51	Recovery Room	719,430					51
52	Delivery Room & Labor Room	835,892					52
53	Anesthesiology	602,298					53
54	Radiology-Diagnostic	4,127,383					54
55	Radiology-Therapeutic	1,960,339					55
57	CT Scan	2,422,862					57
58	MRI	1,371,881					58
59	Cardiac Catheterization	5,707,295					59
60	Laboratory	13,355,790					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,197,580					65
66	Physical Therapy	3,604,202					66
67	Occupational Therapy	385,862					67
68	Speech Pathology	273,497					68
69	Electrocardiology	654,495					69
71	Medical Supplies Charged to Patients	15,357,350					71
73	Drugs Charged to Patients	23,193,531					73
74	Renal Dialysis	7,418,633					74
75	ASC (Non-Distinct Part)	5,134,483					75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	881,730					76.01
76.02	GI	2,348,905					76.02
76.03	NUCLEAR MED	896,060					76.03
76.04	PSYCH	3,712,012					76.04
76.05	ULTRASOUND	989,954					76.05
76.06	VASCULAR LAB	1,254,038					76.06
76.07	MEDICAL OUTPATIENT	787,602					76.07
76.97	CARDIAC REHABILITATION	509,295					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	410,792					76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	11,070,104					91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,403,092					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
116	Hospice	5,318,151					116
118	SUBTOTALS (sum of lines 1-117)	153,950,348					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	235,764					190
194	PATHOLOGY	104,213					194
194.01	PHYSIATRY CLINIC	717,783					194.01
194.02	JANESVILLE MED CENTER	589,112					194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	3,164,127					194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
194.04	ASSISTED LIVING CENTERS	9,015,572						194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	6,215,082						194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,992,001						202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		3,080,085	761,810	3,841,895	3,841,895		5
6	Maintenance & Repairs							6
7	Operation of Plant		617,910	84,391	702,301	234,980	937,281	7
8	Laundry & Linen Service		29,418	31	29,449	17,937	3,468	8
9	Housekeeping		8,613	694	9,307	56,844	1,015	9
10	Dietary		88,254	6,422	94,676	51,087	10,403	10
11	Cafeteria		81,855	2,623	84,478	7,630	9,649	11
12	Maintenance of Personnel							12
13	Nursing Administration		34,226	189,728	223,954	40,864	4,034	13
14	Central Services & Supply		151,311	270,664	421,975	43,049	17,836	14
15	Pharmacy		50,204	170,612	220,816	77,975	5,918	15
16	Medical Records & Library		193,053	120	193,173	87,544	22,756	16
17	Social Service		9,371		9,371	24,202	1,105	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		796,670	118,781	915,451	323,950	93,909	30
31	Intensive Care Unit		68,055	145,009	213,064	86,059	8,022	31
43	Nursery					6,866		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		221,543	332,065	553,608	116,497	26,115	50
51	Recovery Room		24,193		24,193	13,462	2,852	51
52	Delivery Room & Labor Room					16,963		52
53	Anesthesiology		9,181	13,629	22,810	10,926	1,082	53
54	Radiology-Diagnostic		261,562	206,497	468,059	76,901	30,832	54
55	Radiology-Therapeutic		128,462	94,072	222,534	35,946	15,143	55
57	CT Scan		25,140	142,042	167,182	44,935	2,963	57
58	MRI		17,946	138,601	156,547	27,022	2,115	58
59	Cardiac Catheterization		76,157	729,299	805,456	113,094	8,977	59
60	Laboratory		282,405	183,781	466,186	270,144	33,289	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		47,137	79,732	126,869	45,506	5,556	65
66	Physical Therapy		298,855	23,497	322,352	65,158	35,228	66
67	Occupational Therapy		15,069		15,069	7,643	1,776	67
68	Speech Pathology		8,613		8,613	5,527	1,015	68
69	Electrocardiology		9,276	9,018	18,294	11,733	1,093	69
71	Medical Supplies Charged to Patients					323,234		71
73	Drugs Charged to Patients					427,568		73
74	Renal Dialysis		133,592	20,003	153,595	143,781	15,747	74
75	ASC (Non-Distinct Part)		734,768	558,989	1,293,757	78,620	86,612	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		12,797	12,561	25,358	18,070	1,508	76.01
76.02	GI		58,438	277,305	335,743	41,992	6,889	76.02
76.03	NUCLEAR MED		14,785	60,863	75,648	16,005	1,743	76.03
76.04	PSYCH		119,035	1,639	120,674	76,811	14,031	76.04
76.05	ULTRASOUND		29,475	50,620	80,095	19,317	3,474	76.05
76.06	VASCULAR LAB		37,785	15,700	53,485	24,390	4,454	76.06
76.07	MEDICAL OUTPATIENT		18,930	562	19,492	15,555	2,231	76.07
76.97	CARDIAC REHABILITATION		31,860	1,483	33,343	9,486	3,756	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY			581	581	8,620		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency		498,156	394,279	892,435	206,484	58,721	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		63,531	9,189	72,720	72,404	7,489	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		75,722	17,293	93,015	113,960	8,926	116
118	SUBTOTALS (sum of lines 1-117)		8,463,438	5,124,185	13,587,623	3,516,741	561,732	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		22,187	2,918	25,105	4,390	2,615	190
194	PATHOLOGY		9,825	5,400	15,225	1,940	1,158	194
194.01	PHYSIATRY CLINIC		12,759		12,759	15,380	1,504	194.01
194.02	JANESVILLE MED CENTER		95,164	2,475	97,639	9,491	11,218	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS		165,206	9,759	174,965	63,580	19,474	194.03

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
194.04	ASSISTED LIVING CENTERS		1,801,860	18,407	1,820,267	132,810	212,398	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER		1,078,943	34,784	1,113,727	97,563	127,182	194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		11,649,382	5,197,928	16,847,310	3,841,895	937,281	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	50,854						8
9	Housekeeping		67,166					9
10	Dietary		749	156,915				10
11	Cafeteria		695		102,452			11
12	Maintenance of Personnel							12
13	Nursing Administration		291		2,811	271,954		13
14	Central Services & Supply		1,284		2,030		486,174	14
15	Pharmacy		426		3,436		2,361	15
16	Medical Records & Library		1,639		8,434		1	16
17	Social Service		80		1,406			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	22,582	6,762	137,723	20,458	108,286	19,331	30
31	Intensive Care Unit	2,845	578	19,192	4,373	23,145	5,875	31
43	Nursery				469	2,480		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,427	1,880		4,685	24,798	245,056	50
51	Recovery Room		205		625	3,306	2,301	51
52	Delivery Room & Labor Room				937	4,960		52
53	Anesthesiology		78		312	1,653	5,570	53
54	Radiology-Diagnostic	4,216	2,220		4,061		923	54
55	Radiology-Therapeutic		1,090		781		163	55
57	CT Scan		213		1,718		1,625	57
58	MRI		152		781		104	58
59	Cardiac Catheterization		646		3,124		61,341	59
60	Laboratory		2,397		9,214		3,669	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		400		2,186		3,258	65
66	Physical Therapy	1,171	2,537		4,841		6,893	66
67	Occupational Therapy		128		312		141	67
68	Speech Pathology		73		312		412	68
69	Electrocardiology		79		1,093		537	69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,884	1,134		4,061	21,492	35,630	74
75	ASC (Non-Distinct Part)	1,573	6,236		1,874	9,919	41,933	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		109		625	3,306	4	76.01
76.02	GI		496		1,874	9,919	23,899	76.02
76.03	NUCLEAR MED		125		469		24	76.03
76.04	PSYCH		1,010		3,124		19	76.04
76.05	ULTRASOUND		250		937		591	76.05
76.06	VASCULAR LAB	613	321		937	4,960	127	76.06
76.07	MEDICAL OUTPATIENT		161		781	4,133	2,541	76.07
76.97	CARDIAC REHABILITATION		270		469	2,480	54	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	8,543	4,228		8,902	47,117	19,664	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		539				964	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		643				991	116
118	SUBTOTALS (sum of lines 1-117)	50,854	40,124	156,915	102,452	271,954	486,002	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		188					190
194	PATHOLOGY		83				4	194
194.01	PHYSIATRY CLINIC		108					194.01
194.02	JANESVILLE MED CENTER		808				12	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS		1,402				73	194.03

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	
194.04	ASSISTED LIVING CENTERS		15,295				78	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER		9,158				5	194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	50,854	67,166	156,915	102,452	271,954	486,174	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	310,932						15
16	Medical Records & Library		313,547					16
17	Social Service			36,164				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	207	12,133	36,164	1,696,956		1,696,956	30
31	Intensive Care Unit	268	4,765		368,186		368,186	31
43	Nursery		784		10,599		10,599	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,300	13,371		995,737		995,737	50
51	Recovery Room	56	2,324		49,324		49,324	51
52	Delivery Room & Labor Room		2,043		24,903		24,903	52
53	Anesthesiology	1,515	2,607		46,553		46,553	53
54	Radiology-Diagnostic	90	8,268		595,570		595,570	54
55	Radiology-Therapeutic		8,263		283,920		283,920	55
57	CT Scan	66	23,881		242,583		242,583	57
58	MRI	128	8,152		195,001		195,001	58
59	Cardiac Catheterization	1,568	10,618		1,004,824		1,004,824	59
60	Laboratory	22	42,799		827,720		827,720	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,396		186,171		186,171	65
66	Physical Therapy	7	5,929		444,116		444,116	66
67	Occupational Therapy		908		25,977		25,977	67
68	Speech Pathology		398		16,350		16,350	68
69	Electrocardiology		7,250		40,079		40,079	69
71	Medical Supplies Charged to Patients		52,284		375,518		375,518	71
73	Drugs Charged to Patients	277,069	42,383		747,020		747,020	73
74	Renal Dialysis	17,254	8,547		403,125		403,125	74
75	ASC (Non-Distinct Part)	678	3,370		1,524,572		1,524,572	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		1,140		50,120		50,120	76.01
76.02	GI	721	11,142		432,675		432,675	76.02
76.03	NUCLEAR MED	7,540	4,056		105,610		105,610	76.03
76.04	PSYCH		1,476		217,145		217,145	76.04
76.05	ULTRASOUND	31	4,244		108,939		108,939	76.05
76.06	VASCULAR LAB		2,626		91,913		91,913	76.06
76.07	MEDICAL OUTPATIENT	71	463		45,428		45,428	76.07
76.97	CARDIAC REHABILITATION		484		50,342		50,342	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		1,478		10,679		10,679	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	138	20,318		1,266,550		1,266,550	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	296	755		155,167		155,167	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	35	1,892		219,462		219,462	116
118	SUBTOTALS (sum of lines 1-117)	310,060	313,547	36,164	12,858,834		12,858,834	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				32,298		32,298	190
194	PATHOLOGY				18,410		18,410	194
194.01	PHYSIATRY CLINIC				29,751		29,751	194.01
194.02	JANESVILLE MED CENTER	65			119,233		119,233	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	793			260,287		260,287	194.03

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
194.04	ASSISTED LIVING CENTERS	13			2,180,861		2,180,861	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	1			1,347,636		1,347,636	194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	310,932	313,547	36,164	16,847,310		16,847,310	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	615,377						1
2	Cap Rel Costs-Mvble Equip		4,476,791					2
4	Employee Benefits Department			66,345,517				4
5	Administrative & General	162,705	656,119	10,382,777	-31,086,107	142,905,894		5
6	Maintenance & Repairs							6
7	Operation of Plant	32,641	72,683	1,953,058		8,740,511	420,031	7
8	Laundry & Linen Service	1,554	27	60,272		667,188	1,554	8
9	Housekeeping	455	598	1,399,663		2,114,429	455	9
10	Dietary	4,662	5,531	1,006,828		1,900,283	4,662	10
11	Cafeteria	4,324	2,259	105,410		283,815	4,324	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,808	163,406	1,196,143		1,520,009	1,808	13
14	Central Services & Supply	7,993	233,113	602,783		1,601,299	7,993	14
15	Pharmacy	2,652	146,942	1,872,037		2,900,409	2,652	15
16	Medical Records & Library	10,198	103	2,453,820		3,256,356	10,198	16
17	Social Service	495		651,797		900,230	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	102,302	8,008,171		12,049,934	42,084	30
31	Intensive Care Unit	3,595	124,891	2,022,964		3,201,115	3,595	31
43	Nursery			190,913		255,400		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,703	285,996	2,147,562		4,333,319	11,703	50
51	Recovery Room	1,278		342,666		500,726	1,278	51
52	Delivery Room & Labor Room			471,668		630,988		52
53	Anesthesiology	485	11,738	140,026		406,400	485	53
54	Radiology-Diagnostic	13,817	177,849	1,505,102		2,860,483	13,817	54
55	Radiology-Therapeutic	6,786	81,021	397,932		1,337,081	6,786	55
57	CT Scan	1,328	122,336	821,865		1,671,454	1,328	57
58	MRI	948	119,372	391,604		1,005,150	948	58
59	Cardiac Catheterization	4,023	628,120	1,764,675		4,206,752	4,023	59
60	Laboratory	14,918	158,284	3,197,307		10,048,508	14,918	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,490	68,670	933,568		1,692,698	2,490	65
66	Physical Therapy	15,787	20,237	2,520,645		2,423,681	15,787	66
67	Occupational Therapy	796		218,660		284,286	796	67
68	Speech Pathology	455		161,030		205,589	455	68
69	Electrocardiology	490	7,767	303,190		436,430	490	69
71	Medical Supplies Charged to Patients					12,023,291		71
73	Drugs Charged to Patients					15,903,698		73
74	Renal Dialysis	7,057	17,228	1,655,453		5,348,192	7,057	74
75	ASC (Non-Distinct Part)	38,814	481,438	869,304		2,924,433	38,814	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	676	10,818	282,727		672,164	676	76.01
76.02	GI	3,087	238,833	743,800		1,561,974	3,087	76.02
76.03	NUCLEAR MED	781	52,419	258,789		595,326	781	76.03
76.04	PSYCH	6,288	1,412	1,724,719		2,857,133	6,288	76.04
76.05	ULTRASOUND	1,557	43,597	456,036		718,514	1,557	76.05
76.06	VASCULAR LAB	1,996	13,522	569,054		907,236	1,996	76.06
76.07	MEDICAL OUTPATIENT	1,000	484	399,624		578,586	1,000	76.07
76.97	CARDIAC REHABILITATION	1,683	1,277	236,018		352,844	1,683	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		500			320,637		76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	26,315	339,579	4,297,809		7,680,550	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	1,400,330		2,693,185	3,356	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	4,000	14,894	2,207,770		4,238,937	4,000	116
118	SUBTOTALS (sum of lines 1-117)	447,080	4,413,279	62,325,569	-31,086,107	130,811,223	251,734	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,172	2,513	54,012		163,298	1,172	190
194	PATHOLOGY	519	4,651	38,352		72,144	519	194
194.01	PHYSIATRY CLINIC	674		416,186		572,087	674	194.01
194.02	JANESVILLE MED CENTER	5,027	2,132	160,855		353,038	5,027	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	8,727	8,405	1,475,642		2,364,963	8,727	194.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.04	ASSISTED LIVING CENTERS	95,183	15,853	1,610,785		4,940,101	95,183	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	56,995	29,958	264,116		3,629,040	56,995	194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	11,649,382	5,197,928	22,410,276		31,086,107	10,641,826	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.930480	1.161083	0.337781		0.217529	25.335811	203
204	Cost to be allocated (Per Wkst. B, Part II)					3,841,895	937,281	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.026884	2.231457	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

Health Financial Systems Compu-Max 2552-10

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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	556,000						8
9	Housekeeping		418,022					9
10	Dietary		4,662	16,221				10
11	Cafeteria		4,324		656			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,808		18	329		13
14	Central Services & Supply		7,993		13		11,361,778	14
15	Pharmacy		2,652		22		55,179	15
16	Medical Records & Library		10,198		54		20	16
17	Social Service		495		9			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	246,900	42,084	14,237	131	131	451,755	30
31	Intensive Care Unit	31,100	3,595	1,984	28	28	137,290	31
43	Nursery				3	3		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	81,200	11,703		30	30	5,726,927	50
51	Recovery Room		1,278		4	4	53,767	51
52	Delivery Room & Labor Room				6	6		52
53	Anesthesiology		485		2	2	130,178	53
54	Radiology-Diagnostic	46,100	13,817		26		21,560	54
55	Radiology-Therapeutic		6,786		5		3,799	55
57	CT Scan		1,328		11		37,966	57
58	MRI		948		5		2,423	58
59	Cardiac Catheterization		4,023		20		1,433,538	59
60	Laboratory		14,918		59		85,739	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,490		14		76,150	65
66	Physical Therapy	12,800	15,787		31		161,084	66
67	Occupational Therapy		796		2		3,288	67
68	Speech Pathology		455		2		9,640	68
69	Electrocardiology		490		7		12,551	69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis	20,600	7,057		26	26	832,666	74
75	ASC (Non-Distinct Part)	17,200	38,814		12	12	979,978	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		676		4	4	86	76.01
76.02	GI		3,087		12	12	558,525	76.02
76.03	NUCLEAR MED		781		3		557	76.03
76.04	PSYCH		6,288		20		437	76.04
76.05	ULTRASOUND		1,557		6		13,820	76.05
76.06	VASCULAR LAB	6,700	1,996		6	6	2,977	76.06
76.07	MEDICAL OUTPATIENT		1,000		5	5	59,373	76.07
76.97	CARDIAC REHABILITATION		1,683		3	3	1,252	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	93,400	26,315		57	57	459,557	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				22,528	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice		4,000				23,152	116
118	SUBTOTALS (sum of lines 1-117)	556,000	249,725	16,221	656	329	11,357,762	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,172					190
194	PATHOLOGY		519				83	194
194.01	PHYSIATRY CLINIC		674					194.01
194.02	JANESVILLE MED CENTER		5,027				285	194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS		8,727				1,696	194.03

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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	
194.04	ASSISTED LIVING CENTERS		95,183				1,829	194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER		56,995				123	194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	851,693	2,585,907	2,460,605	481,854	1,920,868	2,211,131	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.531822	6.186055	151.692559	734.533537	5,838.504559	0.194611	203
204	Cost to be allocated (Per Wkst. B, Part II)	50,854	67,166	156,915	102,452	271,954	486,174	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.091464	0.160676	9.673571	156.176829	826.607903	0.042790	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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	16,848,852						15
16	Medical Records & Library		712,086,679					16
17	Social Service	19		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	11,200	27,574,076	100				30
31	Intensive Care Unit	14,500	10,829,957					31
43	Nursery		1,782,856					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	124,645	30,387,799					50
51	Recovery Room	3,024	5,281,863					51
52	Delivery Room & Labor Room		4,643,241					52
53	Anesthesiology	82,071	5,923,867					53
54	Radiology-Diagnostic	4,868	18,791,890					54
55	Radiology-Therapeutic		18,779,186					55
57	CT Scan	3,565	54,274,464					57
58	MRI	6,962	18,526,736					58
59	Cardiac Catheterization	84,972	24,131,867					59
60	Laboratory	1,188	97,270,058					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,445,120					65
66	Physical Therapy	355	13,475,103					66
67	Occupational Therapy	17	2,062,908					67
68	Speech Pathology	9	904,764					68
69	Electrocardiology		16,477,085					69
71	Medical Supplies Charged to Patients		118,310,236					71
73	Drugs Charged to Patients	15,013,912	96,325,506					73
74	Renal Dialysis	934,974	19,425,649					74
75	ASC (Non-Distinct Part)	36,759	7,659,092					75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG		2,589,860					76.01
76.02	GI	39,053	25,322,807					76.02
76.03	NUCLEAR MED	408,560	9,217,150					76.03
76.04	PSYCH		3,355,339					76.04
76.05	ULTRASOUND	1,684	9,646,187					76.05
76.06	VASCULAR LAB		5,967,873					76.06
76.07	MEDICAL OUTPATIENT	3,828	1,051,336					76.07
76.97	CARDIAC REHABILITATION		1,099,856					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY		3,359,110					76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	7,455	46,178,329					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	16,023	1,716,392					101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,908	4,299,117					116
118	SUBTOTALS (sum of lines 1-117)	16,801,551	712,086,679	100				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.01	PHYSIATRY CLINIC	25						194.01

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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				
194.02	JANESVILLE MED CENTER	3,532						194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS	42,997						194.03
194.04	ASSISTED LIVING CENTERS	708						194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER	39						194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,641,826	4,325,837	1,118,274				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.216147	0.006075	11,182.740000				203
204	Cost to be allocated (Per Wkst. B, Part II)	310,932	313,547	36,164				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.018454	0.000440	361.640000				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET			
		CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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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	20,772,753		20,772,753		20,772,753	30
31	Intensive Care Unit	4,639,058		4,639,058		4,639,058	31
43	Nursery	341,508		341,508		341,508	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,292,491		7,292,491		7,292,491	50
51	Recovery Room	719,430		719,430		719,430	51
52	Delivery Room & Labor Room	835,892		835,892		835,892	52
53	Anesthesiology	602,298		602,298		602,298	53
54	Radiology-Diagnostic	4,127,383		4,127,383		4,127,383	54
55	Radiology-Therapeutic	1,960,339		1,960,339		1,960,339	55
57	CT Scan	2,422,862		2,422,862		2,422,862	57
58	MRI	1,371,881		1,371,881		1,371,881	58
59	Cardiac Catheterization	5,707,295		5,707,295		5,707,295	59
60	Laboratory	13,355,790		13,355,790		13,355,790	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,197,580		2,197,580		2,197,580	65
66	Physical Therapy	3,604,202		3,604,202		3,604,202	66
67	Occupational Therapy	385,862		385,862		385,862	67
68	Speech Pathology	273,497		273,497		273,497	68
69	Electrocardiology	654,495		654,495		654,495	69
71	Medical Supplies Charged to Patients	15,357,350		15,357,350		15,357,350	71
73	Drugs Charged to Patients	23,193,531		23,193,531		23,193,531	73
74	Renal Dialysis	7,418,633		7,418,633		7,418,633	74
75	ASC (Non-Distinct Part)	5,134,483		5,134,483		5,134,483	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	881,730		881,730		881,730	76.01
76.02	GI	2,348,905		2,348,905		2,348,905	76.02
76.03	NUCLEAR MED	896,060		896,060		896,060	76.03
76.04	PSYCH	3,712,012		3,712,012		3,712,012	76.04
76.05	ULTRASOUND	989,954		989,954		989,954	76.05
76.06	VASCULAR LAB	1,254,038		1,254,038		1,254,038	76.06
76.07	MEDICAL OUTPATIENT	787,602		787,602		787,602	76.07
76.97	CARDIAC REHABILITATION	509,295		509,295		509,295	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	410,792		410,792		410,792	76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic				125,265	125,265	90
91	Emergency	11,070,104		11,070,104		11,070,104	91
92	Observation Beds (Non-Distinct Part)	1,706,522		1,706,522		1,706,522	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,403,092		3,403,092		3,403,092	101
113	Interest Expense						113
116	Hospice	5,318,151		5,318,151		5,318,151	116
200	Subtotal (sum of lines 30 thru 199)	155,656,870		155,656,870	125,265	155,782,135	200
201	Less Observation Beds	1,706,522		1,706,522		1,706,522	201
202	Total (line 200 minus line 201)	153,950,348		153,950,348		154,075,613	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	25,682,880		25,682,880				30
31	Intensive Care Unit	10,829,957		10,829,957				31
43	Nursery	1,782,856		1,782,856				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,308,362	18,079,437	30,387,799	0.239981	0.239981	0.239981	50
51	Recovery Room	711,989	4,569,874	5,281,863	0.136208	0.136208	0.136208	51
52	Delivery Room & Labor Room	3,432,744	1,210,497	4,643,241	0.180023	0.180023	0.180023	52
53	Anesthesiology	1,991,764	3,932,103	5,923,867	0.101673	0.101673	0.101673	53
54	Radiology-Diagnostic	2,667,391	16,124,499	18,791,890	0.219636	0.219636	0.219636	54
55	Radiology-Therapeutic	250,698	18,528,488	18,779,186	0.104389	0.104389	0.104389	55
57	CT Scan	11,829,827	42,444,637	54,274,464	0.044641	0.044641	0.044641	57
58	MRI	3,455,545	15,071,191	18,526,736	0.074049	0.074049	0.074049	58
59	Cardiac Catheterization	12,160,162	11,971,705	24,131,867	0.236504	0.236504	0.236504	59
60	Laboratory	28,208,924	69,061,134	97,270,058	0.137306	0.137306	0.137306	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,206,611	2,238,509	5,445,120	0.403587	0.403587	0.403587	65
66	Physical Therapy	1,967,714	11,507,389	13,475,103	0.267471	0.267471	0.267471	66
67	Occupational Therapy	740,863	1,322,045	2,062,908	0.187048	0.187048	0.187048	67
68	Speech Pathology	272,839	631,925	904,764	0.302285	0.302285	0.302285	68
69	Electrocardiology	4,700,474	11,776,611	16,477,085	0.039722	0.039722	0.039722	69
71	Medical Supplies Charged to Patients	53,090,073	65,220,163	118,310,236	0.129806	0.129806	0.129806	71
73	Drugs Charged to Patients	20,264,202	76,061,304	96,325,506	0.240783	0.240783	0.240783	73
74	Renal Dialysis	1,105,577	18,320,072	19,425,649	0.381899	0.381899	0.381899	74
75	ASC (Non-Distinct Part)		7,659,092	7,659,092	0.670378	0.670378	0.670378	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	105,182	2,484,678	2,589,860	0.340455	0.340455	0.340455	76.01
76.02	GI	1,447,898	23,874,909	25,322,807	0.092758	0.092758	0.092758	76.02
76.03	NUCLEAR MED	1,139,179	8,077,971	9,217,150	0.097217	0.097217	0.097217	76.03
76.04	PSYCH		3,355,339	3,355,339	1.106300	1.106300	1.106300	76.04
76.05	ULTRASOUND	939,745	8,706,442	9,646,187	0.102626	0.102626	0.102626	76.05
76.06	VASCULAR LAB	1,859,296	4,108,577	5,967,873	0.210131	0.210131	0.210131	76.06
76.07	MEDICAL OUTPATIENT		1,051,336	1,051,336	0.749144	0.749144	0.749144	76.07
76.97	CARDIAC REHABILITATION	1,566	1,098,290	1,099,856	0.463056	0.463056	0.463056	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	335,086	3,024,024	3,359,110	0.122292	0.122292	0.122292	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	7,778,164	38,400,165	46,178,329	0.239725	0.239725	0.239725	91
92	Observation Beds (Non-Distinct Part)		1,891,196	1,891,196	0.902351	0.902351	0.902351	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,716,392	1,716,392				101
113	Interest Expense							113
116	Hospice		4,299,117	4,299,117				116
200	Subtotal (sum of lines 30 thru 199)	214,267,568	497,819,111	712,086,679				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,267,568	497,819,111	712,086,679				202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	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						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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	25,682,880		25,682,880				30
31	Intensive Care Unit	10,829,957		10,829,957				31
43	Nursery	1,782,856		1,782,856				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,308,362	18,079,437	30,387,799				50
51	Recovery Room	711,989	4,569,874	5,281,863				51
52	Delivery Room & Labor Room	3,432,744	1,210,497	4,643,241				52
53	Anesthesiology	1,991,764	3,932,103	5,923,867				53
54	Radiology-Diagnostic	2,667,391	16,124,499	18,791,890				54
55	Radiology-Therapeutic	250,698	18,528,488	18,779,186				55
57	CT Scan	11,829,827	42,444,637	54,274,464				57
58	MRI	3,455,545	15,071,191	18,526,736				58
59	Cardiac Catheterization	12,160,162	11,971,705	24,131,867				59
60	Laboratory	28,208,924	69,061,134	97,270,058				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,206,611	2,238,509	5,445,120				65
66	Physical Therapy	1,967,714	11,507,389	13,475,103				66
67	Occupational Therapy	740,863	1,322,045	2,062,908				67
68	Speech Pathology	272,839	631,925	904,764				68
69	Electrocardiology	4,700,474	11,776,611	16,477,085				69
71	Medical Supplies Charged to Patients	53,090,073	65,220,163	118,310,236				71
73	Drugs Charged to Patients	20,264,202	76,061,304	96,325,506				73
74	Renal Dialysis	1,105,577	18,320,072	19,425,649				74
75	ASC (Non-Distinct Part)		7,659,092	7,659,092				75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	105,182	2,484,678	2,589,860				76.01
76.02	GI	1,447,898	23,874,909	25,322,807				76.02
76.03	NUCLEAR MED	1,139,179	8,077,971	9,217,150				76.03
76.04	PSYCH		3,355,339	3,355,339				76.04
76.05	ULTRASOUND	939,745	8,706,442	9,646,187				76.05
76.06	VASCULAR LAB	1,859,296	4,108,577	5,967,873				76.06
76.07	MEDICAL OUTPATIENT		1,051,336	1,051,336				76.07
76.97	CARDIAC REHABILITATION	1,566	1,098,290	1,099,856				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	335,086	3,024,024	3,359,110				76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	7,778,164	38,400,165	46,178,329				91
92	Observation Beds (Non-Distinct Part)		1,891,196	1,891,196				92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,716,392	1,716,392				101
113	Interest Expense							113
116	Hospice		4,299,117	4,299,117				116
200	Subtotal (sum of lines 30 thru 199)	214,267,568	497,819,111	712,086,679				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,267,568	497,819,111	712,086,679				202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 (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	20,772,753		20,772,753		20,772,753	30
31	Intensive Care Unit	4,639,058		4,639,058		4,639,058	31
43	Nursery	341,508		341,508		341,508	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,292,491		7,292,491		7,292,491	50
51	Recovery Room	719,430		719,430		719,430	51
52	Delivery Room & Labor Room	835,892		835,892		835,892	52
53	Anesthesiology	602,298		602,298		602,298	53
54	Radiology-Diagnostic	4,127,383		4,127,383		4,127,383	54
55	Radiology-Therapeutic	1,960,339		1,960,339		1,960,339	55
57	CT Scan	2,422,862		2,422,862		2,422,862	57
58	MRI	1,371,881		1,371,881		1,371,881	58
59	Cardiac Catheterization	5,707,295		5,707,295		5,707,295	59
60	Laboratory	13,355,790		13,355,790		13,355,790	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,197,580		2,197,580		2,197,580	65
66	Physical Therapy	3,604,202		3,604,202		3,604,202	66
67	Occupational Therapy	385,862		385,862		385,862	67
68	Speech Pathology	273,497		273,497		273,497	68
69	Electrocardiology	654,495		654,495		654,495	69
71	Medical Supplies Charged to Patients	15,357,350		15,357,350		15,357,350	71
73	Drugs Charged to Patients	23,193,531		23,193,531		23,193,531	73
74	Renal Dialysis	7,418,633		7,418,633		7,418,633	74
75	ASC (Non-Distinct Part)	5,134,483		5,134,483		5,134,483	75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	881,730		881,730		881,730	76.01
76.02	GI	2,348,905		2,348,905		2,348,905	76.02
76.03	NUCLEAR MED	896,060		896,060		896,060	76.03
76.04	PSYCH	3,712,012		3,712,012		3,712,012	76.04
76.05	ULTRASOUND	989,954		989,954		989,954	76.05
76.06	VASCULAR LAB	1,254,038		1,254,038		1,254,038	76.06
76.07	MEDICAL OUTPATIENT	787,602		787,602		787,602	76.07
76.97	CARDIAC REHABILITATION	509,295		509,295		509,295	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	410,792		410,792		410,792	76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic				125,265	125,265	90
91	Emergency	11,070,104		11,070,104		11,070,104	91
92	Observation Beds (Non-Distinct Part)	1,706,522		1,706,522		1,706,522	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	3,403,092		3,403,092		3,403,092	101
113	Interest Expense						113
116	Hospice	5,318,151		5,318,151		5,318,151	116
200	Subtotal (sum of lines 30 thru 199)	155,656,870		155,656,870	125,265	155,782,135	200
201	Less Observation Beds	1,706,522		1,706,522		1,706,522	201
202	Total (line 200 minus line 201)	153,950,348		153,950,348	125,265	154,075,613	202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	25,682,880		25,682,880				30
31	Intensive Care Unit	10,829,957		10,829,957				31
43	Nursery	1,782,856		1,782,856				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,308,362	18,079,437	30,387,799	0.239981	0.239981	0.239981	50
51	Recovery Room	711,989	4,569,874	5,281,863	0.136208	0.136208	0.136208	51
52	Delivery Room & Labor Room	3,432,744	1,210,497	4,643,241	0.180023	0.180023	0.180023	52
53	Anesthesiology	1,991,764	3,932,103	5,923,867	0.101673	0.101673	0.101673	53
54	Radiology-Diagnostic	2,667,391	16,124,499	18,791,890	0.219636	0.219636	0.219636	54
55	Radiology-Therapeutic	250,698	18,528,488	18,779,186	0.104389	0.104389	0.104389	55
57	CT Scan	11,829,827	42,444,637	54,274,464	0.044641	0.044641	0.044641	57
58	MRI	3,455,545	15,071,191	18,526,736	0.074049	0.074049	0.074049	58
59	Cardiac Catheterization	12,160,162	11,971,705	24,131,867	0.236504	0.236504	0.236504	59
60	Laboratory	28,208,924	69,061,134	97,270,058	0.137306	0.137306	0.137306	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,206,611	2,238,509	5,445,120	0.403587	0.403587	0.403587	65
66	Physical Therapy	1,967,714	11,507,389	13,475,103	0.267471	0.267471	0.267471	66
67	Occupational Therapy	740,863	1,322,045	2,062,908	0.187048	0.187048	0.187048	67
68	Speech Pathology	272,839	631,925	904,764	0.302285	0.302285	0.302285	68
69	Electrocardiology	4,700,474	11,776,611	16,477,085	0.039722	0.039722	0.039722	69
71	Medical Supplies Charged to Patients	53,090,073	65,220,163	118,310,236	0.129806	0.129806	0.129806	71
73	Drugs Charged to Patients	20,264,202	76,061,304	96,325,506	0.240783	0.240783	0.240783	73
74	Renal Dialysis	1,105,577	18,320,072	19,425,649	0.381899	0.381899	0.381899	74
75	ASC (Non-Distinct Part)		7,659,092	7,659,092	0.670378	0.670378	0.670378	75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG	105,182	2,484,678	2,589,860	0.340455	0.340455	0.340455	76.01
76.02	GI	1,447,898	23,874,909	25,322,807	0.092758	0.092758	0.092758	76.02
76.03	NUCLEAR MED	1,139,179	8,077,971	9,217,150	0.097217	0.097217	0.097217	76.03
76.04	PSYCH		3,355,339	3,355,339	1.106300	1.106300	1.106300	76.04
76.05	ULTRASOUND	939,745	8,706,442	9,646,187	0.102626	0.102626	0.102626	76.05
76.06	VASCULAR LAB	1,859,296	4,108,577	5,967,873	0.210131	0.210131	0.210131	76.06
76.07	MEDICAL OUTPATIENT		1,051,336	1,051,336	0.749144	0.749144	0.749144	76.07
76.97	CARDIAC REHABILITATION	1,566	1,098,290	1,099,856	0.463056	0.463056	0.463056	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY	335,086	3,024,024	3,359,110	0.122292	0.122292	0.122292	76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency	7,778,164	38,400,165	46,178,329	0.239725	0.239725	0.239725	91
92	Observation Beds (Non-Distinct Part)		1,891,196	1,891,196	0.902351	0.902351	0.902351	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,716,392	1,716,392				101
113	Interest Expense							113
116	Hospice		4,299,117	4,299,117				116
200	Subtotal (sum of lines 30 thru 199)	214,267,568	497,819,111	712,086,679				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	214,267,568	497,819,111	712,086,679				202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	7,292,491	995,737	6,296,754		50
51	Recovery Room	719,430	49,324	670,106		51
52	Delivery Room & Labor Room	835,892	24,903	810,989		52
53	Anesthesiology	602,298	46,553	555,745		53
54	Radiology-Diagnostic	4,127,383	595,570	3,531,813		54
55	Radiology-Therapeutic	1,960,339	283,920	1,676,419		55
57	CT Scan	2,422,862	242,583	2,180,279		57
58	MRI	1,371,881	195,001	1,176,880		58
59	Cardiac Catheterization	5,707,295	1,004,824	4,702,471		59
60	Laboratory	13,355,790	827,720	12,528,070		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,197,580	186,171	2,011,409		65
66	Physical Therapy	3,604,202	444,116	3,160,086		66
67	Occupational Therapy	385,862	25,977	359,885		67
68	Speech Pathology	273,497	16,350	257,147		68
69	Electrocardiology	654,495	40,079	614,416		69
71	Medical Supplies Charged to Patients	15,357,350	375,518	14,981,832		71
73	Drugs Charged to Patients	23,193,531	747,020	22,446,511		73
74	Renal Dialysis	7,418,633	403,125	7,015,508		74
75	ASC (Non-Distinct Part)	5,134,483	1,524,572	3,609,911		75
76	OTHER ANCILLARY					76
76.01	SLEEP/EEG	881,730	50,120	831,610		76.01
76.02	GI	2,348,905	432,675	1,916,230		76.02
76.03	NUCLEAR MED	896,060	105,610	790,450		76.03
76.04	PSYCH	3,712,012	217,145	3,494,867		76.04
76.05	ULTRASOUND	989,954	108,939	881,015		76.05
76.06	VASCULAR LAB	1,254,038	91,913	1,162,125		76.06
76.07	MEDICAL OUTPATIENT	787,602	45,428	742,174		76.07
76.97	CARDIAC REHABILITATION	509,295	50,342	458,953		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY	410,792	10,679	400,113		76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic					90
91	Emergency	11,070,104	1,266,550	9,803,554		91
92	Observation Beds (Non-Distinct Part)	1,706,522	139,407	1,567,115		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	3,403,092	155,167	3,247,925		101
113	Interest Expense					113
116	Hospice	5,318,151	219,462	5,098,689		116
200	Subtotal	129,903,551	10,922,500	118,981,051		200
201	Less Observation Beds	1,706,522	139,407	1,567,115		201
202	Total	128,197,029	10,783,093	117,413,936		202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		7,292,491	30,387,799	0.239981	50
51	Recovery Room		719,430	5,281,863	0.136208	51
52	Delivery Room & Labor Room		835,892	4,643,241	0.180023	52
53	Anesthesiology		602,298	5,923,867	0.101673	53
54	Radiology-Diagnostic		4,127,383	18,791,890	0.219636	54
55	Radiology-Therapeutic		1,960,339	18,779,186	0.104389	55
57	CT Scan		2,422,862	54,274,464	0.044641	57
58	MRI		1,371,881	18,526,736	0.074049	58
59	Cardiac Catheterization		5,707,295	24,131,867	0.236504	59
60	Laboratory		13,355,790	97,270,058	0.137306	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		2,197,580	5,445,120	0.403587	65
66	Physical Therapy		3,604,202	13,475,103	0.267471	66
67	Occupational Therapy		385,862	2,062,908	0.187048	67
68	Speech Pathology		273,497	904,764	0.302285	68
69	Electrocardiology		654,495	16,477,085	0.039722	69
71	Medical Supplies Charged to Patients		15,357,350	118,310,236	0.129806	71
73	Drugs Charged to Patients		23,193,531	96,325,506	0.240783	73
74	Renal Dialysis		7,418,633	19,425,649	0.381899	74
75	ASC (Non-Distinct Part)		5,134,483	7,659,092	0.670378	75
76	OTHER ANCILLARY					76
76.01	SLEEP/EEG		881,730	2,589,860	0.340455	76.01
76.02	GI		2,348,905	25,322,807	0.092758	76.02
76.03	NUCLEAR MED		896,060	9,217,150	0.097217	76.03
76.04	PSYCH		3,712,012	3,355,339	1.106300	76.04
76.05	ULTRASOUND		989,954	9,646,187	0.102626	76.05
76.06	VASCULAR LAB		1,254,038	5,967,873	0.210131	76.06
76.07	MEDICAL OUTPATIENT		787,602	1,051,336	0.749144	76.07
76.97	CARDIAC REHABILITATION		509,295	1,099,856	0.463056	76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY		410,792	3,359,110	0.122292	76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic					90
91	Emergency		11,070,104	46,178,329	0.239725	91
92	Observation Beds (Non-Distinct Part)		1,706,522	1,891,196	0.902351	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		3,403,092	1,716,392	1.982701	101
113	Interest Expense					113
116	Hospice		5,318,151	4,299,117	1.237033	116
200	Subtotal		129,903,551	673,790,986		200
201	Less Observation Beds		1,706,522	1,891,196		201
202	Total		128,197,029	671,899,790		202

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,696,956		1,696,956	15,167	111.88	6,457	722,409	30
31	Intensive Care Unit	368,186		368,186	1,984	185.58	1,055	195,787	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	10,599		10,599	908	11.67			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,075,741		2,075,741	18,059		7,512	918,196	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 [XX] Title XVIII, Part A [] IPF [] PARHM Demo [] 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	995,737	30,387,799	0.032768	5,306,376	173,879	50
51	Recovery Room	49,324	5,281,863	0.009338	264,628	2,471	51
52	Delivery Room & Labor Room	24,903	4,643,241	0.005363	24,440	131	52
53	Anesthesiology	46,553	5,923,867	0.007859	776,763	6,105	53
54	Radiology-Diagnostic	595,570	18,791,890	0.031693	1,404,866	44,524	54
55	Radiology-Therapeutic	283,920	18,779,186	0.015119	85,214	1,288	55
57	CT Scan	242,583	54,274,464	0.004470	5,631,720	25,174	57
58	MRI	195,001	18,526,736	0.010525	1,399,746	14,732	58
59	Cardiac Catheterization	1,004,824	24,131,867	0.041639	5,717,173	238,057	59
60	Laboratory	827,720	97,270,058	0.008510	13,535,359	115,186	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	186,171	5,445,120	0.034190	1,651,562	56,467	65
66	Physical Therapy	444,116	13,475,103	0.032958	1,003,577	33,076	66
67	Occupational Therapy	25,977	2,062,908	0.012592	405,235	5,103	67
68	Speech Pathology	16,350	904,764	0.018071	144,058	2,603	68
69	Electrocardiology	40,079	16,477,085	0.002432	2,372,273	5,769	69
71	Medical Supplies Charged to Pat	375,518	118,310,236	0.003174	24,702,962	78,407	71
73	Drugs Charged to Patients	747,020	96,325,506	0.007755	9,782,284	75,862	73
74	Renal Dialysis	403,125	19,425,649	0.020752	843,363	17,501	74
75	ASC (Non-Distinct Part)	1,524,572	7,659,092	0.199054			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	50,120	2,589,860	0.019352	47,810	925	76.01
76.02	GI	432,675	25,322,807	0.017086	670,508	11,456	76.02
76.03	NUCLEAR MED	105,610	9,217,150	0.011458	462,621	5,301	76.03
76.04	PSYCH	217,145	3,355,339	0.064716			76.04
76.05	ULTRASOUND	108,939	9,646,187	0.011293	383,092	4,326	76.05
76.06	VASCULAR LAB	91,913	5,967,873	0.015401	849,961	13,090	76.06
76.07	MEDICAL OUTPATIENT	45,428	1,051,336	0.043210			76.07
76.97	CARDIAC REHABILITATION	50,342	1,099,856	0.045771	1,565	72	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	10,679	3,359,110	0.003179			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,266,550	46,178,329	0.027427	3,695,860	101,366	91
92	Observation Beds (Non-Distinct	139,407	1,891,196	0.073714			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	10,547,871	667,775,477		81,163,016	1,032,871	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
 Applicable ☒ Title XVIII, Part A
 Boxes: ☐ Title XIX

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		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)	15,167		6,457		30
31	Intensive Care Unit	1,984		1,055		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	908				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	18,059		7,512		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 52-0100

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ 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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	30,387,799			5,306,376		8,126,850		50
51	Recovery Room	5,281,863			264,628		1,285,427		51
52	Delivery Room & Labor Room	4,643,241			24,440		6,930		52
53	Anesthesiology	5,923,867			776,763		1,034,452		53
54	Radiology-Diagnostic	18,791,890			1,404,866		4,941,047		54
55	Radiology-Therapeutic	18,779,186			85,214		9,358,665		55
57	CT Scan	54,274,464			5,631,720		13,156,033		57
58	MRI	18,526,736			1,399,746		3,931,458		58
59	Cardiac Catheterization	24,131,867			5,717,173		5,377,999		59
60	Laboratory	97,270,058			13,535,359		11,724,234		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,445,120			1,651,562		618,881		65
66	Physical Therapy	13,475,103			1,003,577		259,882		66
67	Occupational Therapy	2,062,908			405,235		14,459		67
68	Speech Pathology	904,764			144,058		4,540		68
69	Electrocardiology	16,477,085			2,372,273		4,193,444		69
71	Medical Supplies Charged to Pat	118,310,236			24,702,962		19,901,614		71
73	Drugs Charged to Patients	96,325,506			9,782,284		29,586,557		73
74	Renal Dialysis	19,425,649			843,363		33,208		74
75	ASC (Non-Distinct Part)	7,659,092							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	2,589,860			47,810		724,732		76.01
76.02	GI	25,322,807			670,508		6,863,638		76.02
76.03	NUCLEAR MED	9,217,150			462,621		3,284,511		76.03
76.04	PSYCH	3,355,339					581,838		76.04
76.05	ULTRASOUND	9,646,187			383,092		1,680,691		76.05
76.06	VASCULAR LAB	5,967,873			849,961		1,373,886		76.06
76.07	MEDICAL OUTPATIENT	1,051,336							76.07
76.97	CARDIAC REHABILITATION	1,099,856			1,565		529,131		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	3,359,110							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	46,178,329			3,695,860		6,581,247		91
92	Observation Beds (Non-Distinct	1,891,196					603,116		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	667,775,477			81,163,016		135,778,470		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 52-0100

WORKSHEET D
PART V

Check [] Title V - 0/P [XX] Hospital [] SNF [] ICF/IID
Applicable [XX] Title XVIII, Part B [] IPF [] NF [] PARHM Demonstration
Boxes: [] Title XIX - 0/P [] IRF [] Swing Bed SNF [] PARHM CAH Swing Bed SNF
[] SUB [] Swing Bed NF
(Other)

			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	0.239981	8,126,850			1,950,290			50
51	Recovery Room	0.136208	1,285,427			175,085			51
52	Delivery Room & Labor Room	0.180023	6,930			1,248			52
53	Anesthesiology	0.101673	1,034,452			105,176			53
54	Radiology-Diagnostic	0.219636	4,941,047			1,085,232			54
55	Radiology-Therapeutic	0.104389	9,358,665			976,942			55
57	CT Scan	0.044641	13,156,033			587,298			57
58	MRI	0.074049	3,931,458			291,121			58
59	Cardiac Catheterization	0.236504	5,377,999			1,271,918			59
60	Laboratory	0.137306	11,724,234			1,609,808			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.403587	618,881			249,772			65
66	Physical Therapy	0.267471	259,882			69,511			66
67	Occupational Therapy	0.187048	14,459			2,705			67
68	Speech Pathology	0.302285	4,540			1,372			68
69	Electrocardiology	0.039722	4,193,444			166,572			69
71	Medical Supplies Charged to Pat	0.129806	19,901,614			2,583,349			71
73	Drugs Charged to Patients	0.240783	29,586,557	2,455	283,566	7,123,940	591	68,278	73
74	Renal Dialysis	0.381899	33,208			12,682			74
75	ASC (Non-Distinct Part)	0.670378							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	0.340455	724,732			246,739			76.01
76.02	GI	0.092758	6,863,638			636,657			76.02
76.03	NUCLEAR MED	0.097217	3,284,511			319,310			76.03
76.04	PSYCH	1.106300	581,838			643,687			76.04
76.05	ULTRASOUND	0.102626	1,680,691			172,483			76.05
76.06	VASCULAR LAB	0.210131	1,373,886			288,696			76.06
76.07	MEDICAL OUTPATIENT	0.749144							76.07
76.97	CARDIAC REHABILITATION	0.463056	529,131			245,017			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	0.122292							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	0.239725	6,581,247			1,577,689			91
92	Observation Beds (Non-Distinct	0.902351	603,116			544,222			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		135,778,470	2,455	283,566	22,938,521	591	68,278	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		135,778,470	2,455	283,566	22,938,521	591	68,278	202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

☒ Hospital
☐ PARHM Demonstration

		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)	1,696,956		1,696,956	15,167	111.88	476	53,255	30
31	Intensive Care Unit	368,186		368,186	1,984	185.58	40	7,423	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	10,599		10,599	908	11.67	160	1,867	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,075,741		2,075,741	18,059		676	62,545	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)
Applicable [] Title XVIII, Part A [] IPF [] PARHM Demo
Boxes: [XX] 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	995,737	30,387,799	0.032768	292,515	9,585	50
51	Recovery Room	49,324	5,281,863	0.009338	17,447	163	51
52	Delivery Room & Labor Room	24,903	4,643,241	0.005363	300,141	1,610	52
53	Anesthesiology	46,553	5,923,867	0.007859	55,051	433	53
54	Radiology-Diagnostic	595,570	18,791,890	0.031693	60,746	1,925	54
55	Radiology-Therapeutic	283,920	18,779,186	0.015119	4,518	68	55
57	CT Scan	242,583	54,274,464	0.004470	484,644	2,166	57
58	MRI	195,001	18,526,736	0.010525	97,836	1,030	58
59	Cardiac Catheterization	1,004,824	24,131,867	0.041639	323,061	13,452	59
60	Laboratory	827,720	97,270,058	0.008510	983,741	8,372	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	186,171	5,445,120	0.034190	78,070	2,669	65
66	Physical Therapy	444,116	13,475,103	0.032958	59,269	1,953	66
67	Occupational Therapy	25,977	2,062,908	0.012592	19,103	241	67
68	Speech Pathology	16,350	904,764	0.018071	11,114	201	68
69	Electrocardiology	40,079	16,477,085	0.002432	147,301	358	69
71	Medical Supplies Charged to Pat	375,518	118,310,236	0.003174	1,186,523	3,766	71
73	Drugs Charged to Patients	747,020	96,325,506	0.007755	608,921	4,722	73
74	Renal Dialysis	403,125	19,425,649	0.020752	25,624	532	74
75	ASC (Non-Distinct Part)	1,524,572	7,659,092	0.199054			75
76	OTHER ANCILLARY						76
76.01	SLEEP/EEG	50,120	2,589,860	0.019352	1,366	26	76.01
76.02	GI	432,675	25,322,807	0.017086	47,851	818	76.02
76.03	NUCLEAR MED	105,610	9,217,150	0.011458	21,463	246	76.03
76.04	PSYCH	217,145	3,355,339	0.064716			76.04
76.05	ULTRASOUND	108,939	9,646,187	0.011293	61,900	699	76.05
76.06	VASCULAR LAB	91,913	5,967,873	0.015401	61,545	948	76.06
76.07	MEDICAL OUTPATIENT	45,428	1,051,336	0.043210			76.07
76.97	CARDIAC REHABILITATION	50,342	1,099,856	0.045771			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY	10,679	3,359,110	0.003179			76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic						90
91	Emergency	1,266,550	46,178,329	0.027427	289,295	7,934	91
92	Observation Beds (Non-Distinct	139,407	1,891,196	0.073714			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	10,547,871	667,775,477		5,239,045	63,917	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☐ Title XVIII, Part A
Boxes: ☒ Title XIX

☒ Hospital
☐ PARHM Demonstration

		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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V ☒ Hospital
Applicable ☐ Title XVIII, Part A ☐ PARHM Demonstration
Boxes: ☒ Title XIX

		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)	15,167		476		30
31	Intensive Care Unit	1,984		40		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	908		160		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	18,059		676		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	30,387,799			292,515				50
51	Recovery Room	5,281,863			17,447				51
52	Delivery Room & Labor Room	4,643,241			300,141				52
53	Anesthesiology	5,923,867			55,051				53
54	Radiology-Diagnostic	18,791,890			60,746				54
55	Radiology-Therapeutic	18,779,186			4,518				55
57	CT Scan	54,274,464			484,644				57
58	MRI	18,526,736			97,836				58
59	Cardiac Catheterization	24,131,867			323,061				59
60	Laboratory	97,270,058			983,741				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,445,120			78,070				65
66	Physical Therapy	13,475,103			59,269				66
67	Occupational Therapy	2,062,908			19,103				67
68	Speech Pathology	904,764			11,114				68
69	Electrocardiology	16,477,085			147,301				69
71	Medical Supplies Charged to Pat	118,310,236			1,186,523				71
73	Drugs Charged to Patients	96,325,506			608,921				73
74	Renal Dialysis	19,425,649			25,624				74
75	ASC (Non-Distinct Part)	7,659,092							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	2,589,860			1,366				76.01
76.02	GI	25,322,807			47,851				76.02
76.03	NUCLEAR MED	9,217,150			21,463				76.03
76.04	PSYCH	3,355,339							76.04
76.05	ULTRASOUND	9,646,187			61,900				76.05
76.06	VASCULAR LAB	5,967,873			61,545				76.06
76.07	MEDICAL OUTPATIENT	1,051,336							76.07
76.97	CARDIAC REHABILITATION	1,099,856							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	3,359,110							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	46,178,329			289,295				91
92	Observation Beds (Non-Distinct	1,891,196							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	667,775,477			5,239,045				200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 52-0100

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SNF [] ICF/IID
Applicable [] Title XVIII, Part B [] IPF [] NF [] PARHM Demonstration
Boxes: [XX] Title XIX - O/P [] IRF [] Swing Bed SNF [] PARHM CAH Swing Bed SNF
[] SUB [] Swing Bed NF
(Other)

			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	0.239981		403,241			96,770		50
51	Recovery Room	0.136208		82,354			11,217		51
52	Delivery Room & Labor Room	0.180023		77,786			14,003		52
53	Anesthesiology	0.101673		63,008			6,406		53
54	Radiology-Diagnostic	0.219636		422,957			92,897		54
55	Radiology-Therapeutic	0.104389		446,584			46,618		55
57	CT Scan	0.044641		1,237,837			55,258		57
58	MRI	0.074049		333,355			24,685		58
59	Cardiac Catheterization	0.236504		208,352			49,276		59
60	Laboratory	0.137306		2,671,520			366,816		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.403587		65,828			26,567		65
66	Physical Therapy	0.267471		99,724			26,673		66
67	Occupational Therapy	0.187048		29,032			5,430		67
68	Speech Pathology	0.302285		62,949			19,029		68
69	Electrocardiology	0.039722		168,399			6,689		69
71	Medical Supplies Charged to Pat	0.129806		1,098,460			142,587		71
73	Drugs Charged to Patients	0.240783		2,008,696			483,660		73
74	Renal Dialysis	0.381899		1,148,307			438,537		74
75	ASC (Non-Distinct Part)	0.670378							75
76	OTHER ANCILLARY								76
76.01	SLEEP/EEG	0.340455		30,011			10,217		76.01
76.02	GI	0.092758		261,138			24,223		76.02
76.03	NUCLEAR MED	0.097217		115,206			11,200		76.03
76.04	PSYCH	1.106300		158,974			175,873		76.04
76.05	ULTRASOUND	0.102626		453,323			46,523		76.05
76.06	VASCULAR LAB	0.210131		101,114			21,247		76.06
76.07	MEDICAL OUTPATIENT	0.749144							76.07
76.97	CARDIAC REHABILITATION	0.463056		313			145		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	0.122292							76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic								90
91	Emergency	0.239725		2,170,300			520,275		91
92	Observation Beds (Non-Distinct	0.902351		58,654			52,926		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			13,977,422			2,775,747		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			13,977,422			2,775,747		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 ☐ PARHM Demo ☐ 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)	15,167	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,167	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)	13,921	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)	6,457	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)	20,772,753	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)	20,772,753	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)	20,772,753	37

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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** ☐ **PARHM Demo** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,369.60	38
39	Program general inpatient routine service cost (line 9 x line 38)					8,843,507	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					8,843,507	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	4,639,058	1,984	2,338.23	1,055	2,466,833	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,536,692	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	24,847,032	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	918,196	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,032,871	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,951,067	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	22,895,965	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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,246	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,369.60	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,706,522	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	1,696,956	20,772,753	0.081691	1,706,522	139,407	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 52-0100****WORKSHEET D-1
PART I**

Check Applicable Boxes:	[] Title V - I/P [] Title XVIII, Part A [XX] Title XIX - I/P	[XX] Hospital [] IPF [] IRF	[] SUB (Other) [] SNF [] NF	[] ICF/IID [] PARHM Demo	[] PPS [] TEFRA [XX] Other
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PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,167	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,167	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)	13,921	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)	476	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)	908	15
16	Nursery days (title V or XIX only)	160	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)	20,772,753	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)	20,772,753	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)	20,772,753	37

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 52-0100

WORKSHEET D-1 PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,369.60 38
39	Program general inpatient routine service cost (line 9 x line 38)						651,930 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)						651,930 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)	341,508	908	376.11	160	60,178	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,639,058	1,984	2,338.23	40	93,529	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)					852,571	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,658,208	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					62,545	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					63,917	51
52	Total Program excludable cost (sum of lines 50 and 51)					126,462	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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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
☐ PARHM Demo

☐ PPS
☐ TEFRA
☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,246	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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 52-0100

WORKSHEET D-3

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

		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		11,538,306		30
31	Intensive Care Unit		5,646,068		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.239981	5,306,376	1,273,429	50
51	Recovery Room	0.136208	264,628	36,044	51
52	Delivery Room & Labor Room	0.180023	24,440	4,400	52
53	Anesthesiology	0.101673	776,763	78,976	53
54	Radiology-Diagnostic	0.219636	1,404,866	308,559	54
55	Radiology-Therapeutic	0.104389	85,214	8,895	55
57	CT Scan	0.044641	5,631,720	251,406	57
58	MRI	0.074049	1,399,746	103,650	58
59	Cardiac Catheterization	0.236504	5,717,173	1,352,134	59
60	Laboratory	0.137306	13,535,359	1,858,486	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.403587	1,651,562	666,549	65
66	Physical Therapy	0.267471	1,003,577	268,428	66
67	Occupational Therapy	0.187048	405,235	75,798	67
68	Speech Pathology	0.302285	144,058	43,547	68
69	Electrocardiology	0.039722	2,372,273	94,231	69
71	Medical Supplies Charged to Patients	0.129806	24,702,962	3,206,593	71
73	Drugs Charged to Patients	0.240783	9,782,284	2,355,408	73
74	Renal Dialysis	0.381899	843,363	322,079	74
75	ASC (Non-Distinct Part)	0.670378			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.340455	47,810	16,277	76.01
76.02	GI	0.092758	670,508	62,195	76.02
76.03	NUCLEAR MED	0.097217	462,621	44,975	76.03
76.04	PSYCH	1.106300			76.04
76.05	ULTRASOUND	0.102626	383,092	39,315	76.05
76.06	VASCULAR LAB	0.210131	849,961	178,603	76.06
76.07	MEDICAL OUTPATIENT	0.749144			76.07
76.97	CARDIAC REHABILITATION	0.463056	1,565	725	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	0.122292			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.239725	3,695,860	885,990	91
92	Observation Beds (Non-Distinct Part)	0.902351			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		81,163,016	13,536,692	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		81,163,016		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 52-0100

WORKSHEET D-3

Check Applicable Boxes: ☐ Title V ☐ Title XVIII, Part A ☒ Title XIX ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF ☐ NF ☐ Swing Bed SNF ☐ Swing Bed NF ☐ ICF/IID ☐ PARHM Demo ☐ PARHM CAH ☐ Swing Bed SNF ☐ PPS ☐ TEFRA ☒ 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		960,463		30
31	Intensive Care Unit		235,720		31
43	Nursery		322,284		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.239981	292,515	70,198	50
51	Recovery Room	0.136208	17,447	2,376	51
52	Delivery Room & Labor Room	0.180023	300,141	54,032	52
53	Anesthesiology	0.101673	55,051	5,597	53
54	Radiology-Diagnostic	0.219636	60,746	13,342	54
55	Radiology-Therapeutic	0.104389	4,518	472	55
57	CT Scan	0.044641	484,644	21,635	57
58	MRI	0.074049	97,836	7,245	58
59	Cardiac Catheterization	0.236504	323,061	76,405	59
60	Laboratory	0.137306	983,741	135,074	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.403587	78,070	31,508	65
66	Physical Therapy	0.267471	59,269	15,853	66
67	Occupational Therapy	0.187048	19,103	3,573	67
68	Speech Pathology	0.302285	11,114	3,360	68
69	Electrocardiology	0.039722	147,301	5,851	69
71	Medical Supplies Charged to Patients	0.129806	1,186,523	154,018	71
73	Drugs Charged to Patients	0.240783	608,921	146,618	73
74	Renal Dialysis	0.381899	25,624	9,786	74
75	ASC (Non-Distinct Part)	0.670378			75
76	OTHER ANCILLARY				76
76.01	SLEEP/EEG	0.340455	1,366	465	76.01
76.02	GI	0.092758	47,851	4,439	76.02
76.03	NUCLEAR MED	0.097217	21,463	2,087	76.03
76.04	PSYCH	1.106300			76.04
76.05	ULTRASOUND	0.102626	61,900	6,353	76.05
76.06	VASCULAR LAB	0.210131	61,545	12,933	76.06
76.07	MEDICAL OUTPATIENT	0.749144			76.07
76.97	CARDIAC REHABILITATION	0.463056			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY	0.122292			76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic				90
91	Emergency	0.239725	289,295	69,351	91
92	Observation Beds (Non-Distinct Part)	0.902351			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,239,045	852,571	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,239,045		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

Check
applicable box: ☒ Hospital
☐ PARHM Hospital

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	12,175,363			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,424,480			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)				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)	871,297			2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)	192,330			2.04
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	93.59			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)	0.0548			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1857			31
32	Sum of lines 30 and 31	0.2405			32
33	Allowable disproportionate share percentage (see instructions)	0.0906			33
34	Disproportionate share adjustment (see instructions)	353,337			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)	8,272,872,447		8,350,599,096	35
35.01	Factor 3 (see instructions)	0.000140902		0.000158566	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,165,664		1,324,121	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	871,853		332,839	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,204,692			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

Check
applicable box: ☒ Hospital
☐ PARHM Hospital

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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)	18,221,499			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)	18,221,499			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,361,669			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)	19,583,168			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	19,583,168			61
62	Deductibles billed to program beneficiaries	1,653,980			62
63	Coinsurance billed to program beneficiaries	11,594			63
64	Allowable bad debts (see instructions)	293,260			64
65	Adjusted reimbursable bad debts (see instructions)	190,619			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	249,126			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,108,213			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)	-131,975			70.93
70.94	HRR adjustment amount (see instructions)	-151,355			70.94
71	Amount due provider (see instructions)	17,824,883			71
71.01	Sequestration adjustment (see instructions)	356,498			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
71.03	Sequestration adjustment - PARHM pass-throughs				71.03
72	Interim payments	16,971,399			72
72.01	Interim payments - PARHM				72.01
73	Tentative settlement (for contractor use only)				73
73.01	Tentative settlement - PARHM (for contractor use only)				73.01
74	Balance due provider/program (line 71 minus lines 71.01, 72 and 73)	496,986			74
74.01	Balance due provider/program - PARHM (see instructions)				74.01
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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 ☐ PARHM Demonstration

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	68,869			1
2	Medical and other services reimbursed under OPPS (see instructions)	22,938,521			2
3	OPPS payments	30,640,555			3
4	Outlier payment (see instructions)	68,851			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	20,002,390			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)	68,869			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	286,021			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)	286,021			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)	286,021			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	217,152			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)	68,869			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)	30,709,406			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	6,063,970			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)	24,714,305			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)	24,714,305			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	24,714,305			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)	812,911			34
35	Adjusted reimbursable bad debts (see instructions)	528,392			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	753,369			36
37	Subtotal (see instructions)	25,242,697			37
38	MSP-LCC reconciliation amount from PS&R	192			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	25,242,505			40
40.01	Sequestration adjustment (see instructions)	504,850			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments	24,152,213			41
41.01	Interim payments - PARHM				41.01
42	Tentative settlement (for contractors use only)				42
42.01	Tentative settlement - PARHM (for contractor use only)				42.01
43	Balance due provider/program (see instructions)	585,442			43
43.01	Balance due provider/program - PARHM (see instructions)				43.01
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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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) ☐ PARHM Demonstration
 Applicable ☐ IPF ☐ SNF ☐ PARHM CAH Swing Bed-SNF
 Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			16,971,399		24,152,213
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)			16,971,399		24,152,213
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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	1,658,208		1
2	Medical and other services		2,775,747	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,658,208	2,775,747	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,658,208	2,775,747	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	5,239,045	13,977,422	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)	5,239,045	13,977,422	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	5,239,045	13,977,422	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,580,837	11,201,675	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)	1,658,208	2,775,747	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)	1,658,208	2,775,747	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)	1,658,208	2,775,747	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)	1,658,208	2,775,747	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	1,658,208	2,775,747	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)	1,658,208	2,775,747	40
41	Interim payments	1,772,849	2,230,808	41
42	Balance due provider/program (line 40 minus line 41)	-114,641	544,939	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

Health Financial Systems Compu-Max 2552-10

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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	13,193,894				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	49,563,099				4
5	Other receivables	4,096,932				5
6	Allowances for uncollectible notes and accounts receivable	-3,978,000				6
7	Inventory	5,365,001				7
8	Prepaid expenses	933,806				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	69,174,732				11
	FIXED ASSETS					
12	Land	8,100,877				12
13	Land improvements	7,358,440				13
14	Accumulated depreciation	-4,773,419				14
15	Buildings	146,406,111				15
16	Accumulated depreciation	-64,546,492				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	41,962,322				19
20	Accumulated depreciation	-27,923,989				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	64,786,677				23
24	Accumulated depreciation	-49,016,443				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)	122,354,084				30
	OTHER ASSETS					
31	Investments	84,804,823				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	7,550,960				34
35	Total other assets (sum of lines 31-34)	92,355,783				35
36	Total assets (sum of lines 11, 30 and 35)	283,884,599				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	6,745,381				37
38	Salaries, wages and fees payable	6,057,860				38
39	Payroll taxes payable	226,360				39
40	Notes and loans payable (short term)	3,373,675				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	12,841,613				44
45	Total current liabilities (sum of lines 37 thru 44)	29,244,889				45
	LONG TERM LIABILITIES					
46	Mortgage payable	77,352,776				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	32,447,905				49
50	Total long term liabilities (sum of lines 46 thru 49)	109,800,681				50
51	Total liabilities (sum of lines 45 and 50)	139,045,570				51
	CAPITAL ACCOUNTS					
52	General fund balance	144,839,029				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	144,839,029				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	283,884,599				60

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		138,532,951		1
2	Net income (loss) (from Worksheet G-3, line 29)		10,699,755		2
3	Total (sum of line 1 and line 2)		149,232,706		3
4	Additions (credit adjustments) (specify)				4
5	ASSETS RELEASED FROM RESTRICTIONS	1,998,559			5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		1,998,559		10
11	Subtotal (line 3 plus line 10)		151,231,265		11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN PENSION OBLIGATION	4,947,527			13
14	CHANGE IN SWAP VALUE	1,350,067			14
15	FOUNDATION RECEIVABLE WRITEDOWN	94,642			15
16					16
17					17
18	Total deductions (sum of lines 12-17)		6,392,236		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		144,839,029		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5	ASSETS RELEASED FROM RESTRICTIONS				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN PENSION OBLIGATION				13
14	CHANGE IN SWAP VALUE				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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	27,120,449		27,120,449	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)	27,120,449		27,120,449	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,508,172		10,508,172	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)	10,508,172		10,508,172	16
17	Total inpatient routine care services (sum of lines 10 and 16)	37,628,621		37,628,621	17
18	Ancillary services	177,455,216	720,711,714	898,166,930	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		1,716,392	1,716,392	22
23	Ambulance				23
25	ASC				25
26	Hospice		4,299,117	4,299,117	26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	215,083,837	726,727,223	941,811,060	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		251,289,175	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)		251,289,175	43

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)	941,811,060	1
2	Less contractual allowances and discounts on patients' accounts	698,490,333	2
3	Net patient revenues (line 1 minus line 2)	243,320,727	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	251,289,175	4
5	Net income from service to patients (line 3 minus line 4)	-7,968,448	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	12,149,853	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	8,142,190	24
25	Total other income (sum of lines 6-24)	20,292,043	25
26	Total (line 5 plus line 25)	12,323,595	26
27	Other expenses (OTHER NON OPERATING EXPENSE)	1,623,840	27
28	Total other expenses (sum of line 27 and subscripts)	1,623,840	28
29	Net income (or loss) for the period (line 26 minus line 28)	10,699,755	29

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	206,962	80,494			134,825	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	678,750	263,986	21,064			6
7	Physical Therapy	377,340	146,759	11,710			7
8	Occupational Therapy	126,422	49,169	3,923			8
9	Speech Pathology	6,952	2,704	216			9
10	Medical Social Services						10
11	Home Health Aide	3,904	1,518	121			11
12	Supplies (see instructions)					22,528	12
13	Drugs					16,023	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)	1,400,330	544,630	37,034		173,376	24

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)	ADJUSTMENTS	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	422,281		422,281	-7,910	414,371	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	963,800		963,800		963,800	6
7	Physical Therapy	535,809		535,809		535,809	7
8	Occupational Therapy	179,514		179,514		179,514	8
9	Speech Pathology	9,872		9,872		9,872	9
10	Medical Social Services						10
11	Home Health Aide	5,543		5,543		5,543	11
12	Supplies (see instructions)	22,528		22,528		22,528	12
13	Drugs	16,023		16,023		16,023	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)	2,155,370		2,155,370	-7,910	2,147,460	24

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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		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	414,371				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	963,800				6
7	Physical Therapy	535,809				7
8	Occupational Therapy	179,514				8
9	Speech Pathology	9,872				9
10	Medical Social Services					10
11	Home Health Aide	5,543				11
12	Supplies (see instructions)	22,528				12
13	Drugs	16,023				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)	2,147,460				24

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		414,371	414,371		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		963,800	230,439	1,194,239	6
7	Physical Therapy		535,809	128,109	663,918	7
8	Occupational Therapy		179,514	42,921	222,435	8
9	Speech Pathology		9,872	2,360	12,232	9
10	Medical Social Services					10
11	Home Health Aide		5,543	1,325	6,868	11
12	Supplies (see instructions)		22,528	5,386	27,914	12
13	Drugs		16,023	3,831	19,854	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)		2,147,460		2,147,460	24

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 52-7075

WORKSHEET H-1 PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	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							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-414,371	1,733,089	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						963,800	6
7	Physical Therapy						535,809	7
8	Occupational Therapy						179,514	8
9	Speech Pathology						9,872	9
10	Medical Social Services							10
11	Home Health Aide						5,543	11
12	Supplies (see instructions)						22,528	12
13	Drugs						16,023	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)					-414,371	1,733,089	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						414,371	25
26	Unit Cost Multiplier						0.239094	26

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		63,531	9,189	69,908	142,628	31,026	1
2	Skilled Nursing Care	1,194,239			229,269	1,423,508	309,654	2
3	Physical Therapy	663,918			127,458	791,376	172,147	3
4	Occupational Therapy	222,435			42,703	265,138	57,675	4
5	Speech Pathology	12,232			2,348	14,580	3,172	5
6	Medical Social Services							6
7	Home Health Aide	6,868			1,319	8,187	1,781	7
8	Supplies	27,914				27,914	6,072	8
9	Drugs	19,854				19,854	4,319	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)	2,147,460	63,531	9,189	473,005	2,693,185	585,846	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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		85,027		20,760			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)		85,027		20,760			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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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			4,384	3,463			1
2	Skilled Nursing Care					5,097		2
3	Physical Therapy					3,819		3
4	Occupational Therapy					1,142		4
5	Speech Pathology					114		5
6	Medical Social Services							6
7	Home Health Aide					255		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)			4,384	3,463	10,427		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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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						287,288	1
2	Skilled Nursing Care						1,738,259	2
3	Physical Therapy						967,342	3
4	Occupational Therapy						323,955	4
5	Speech Pathology						17,866	5
6	Medical Social Services							6
7	Home Health Aide						10,223	7
8	Supplies						33,986	8
9	Drugs						24,173	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)						3,403,092	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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 Pdl)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		287,288					1
2	Skilled Nursing Care		1,738,259	160,273	1,898,532			2
3	Physical Therapy		967,342	89,192	1,056,534			3
4	Occupational Therapy		323,955	29,870	353,825			4
5	Speech Pathology		17,866	1,647	19,513			5
6	Medical Social Services							6
7	Home Health Aide		10,223	943	11,166			7
8	Supplies		33,986	3,134	37,120			8
9	Drugs		24,173	2,229	26,402			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)		3,403,092	287,288	3,403,092			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.			0.092203				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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	206,962		142,628		1
2	Skilled Nursing Care			678,750		1,423,508		2
3	Physical Therapy			377,340		791,376		3
4	Occupational Therapy			126,422		265,138		4
5	Speech Pathology			6,952		14,580		5
6	Medical Social Services							6
7	Home Health Aide			3,904		8,187		7
8	Supplies					27,914		8
9	Drugs					19,854		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	1,400,330		2,693,185		20
21	Total cost to be allocated	63,531	9,189	473,005		585,846		21
22	Unit Cost Multiplier	18.930572		0.337781		0.217529		22
22	Unit Cost Multiplier		1.161107					22

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	85,027		20,760				21
22	Unit Cost Multiplier	25.335816		6.185936				22
22	Unit Cost Multiplier							22

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		22,528	16,023				1
2	Skilled Nursing Care				839,179			2
3	Physical Therapy				628,560			3
4	Occupational Therapy				187,974			4
5	Speech Pathology				18,687			5
6	Medical Social Services							6
7	Home Health Aide				41,992			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)		22,528	16,023	1,716,392			20
21	Total cost to be allocated		4,384	3,463	10,427			21
22	Unit Cost Multiplier			0.216127				22
22	Unit Cost Multiplier		0.194602		0.006075			22

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 20	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R PROGRAM COSTS ASSIGNED TIME 22	PARAMED EDUCATION ASSIGNED TIME 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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		1	2	3	4	5		
1	Skilled Nursing Care	2	1,898,532		1,898,532	3,817	497.39	1
2	Physical Therapy	3	1,056,534		1,056,534	2,859	369.55	2
3	Occupational Therapy	4	353,825		353,825	855	413.83	3
4	Speech Pathology	5	19,513		19,513	85	229.56	4
5	Medical Social Services	6						5
6	Home Health Aide	7	11,166		11,166	191	58.46	6
7	Total (sum of lines 1-6)		3,339,570		3,339,570	7,807		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		1,862		8		
8.01	Skilled Nursing Care	31540		6		8.01		
8.02	Skilled Nursing Care	40420		194		8.02		
8.03	Skilled Nursing Care	99952		25		8.03		
9	Physical Therapy	27500		1,445		9		
9.01	Physical Therapy	31540		6		9.01		
9.02	Physical Therapy	40420		171		9.02		
9.03	Physical Therapy	99952		39		9.03		
10	Occupational Therapy	27500		449		10		
10.01	Occupational Therapy	31540		1		10.01		
10.02	Occupational Therapy	40420		59		10.02		
10.03	Occupational Therapy	99952		14		10.03		
11	Speech Pathology	27500		34		11		
11.01	Speech Pathology	31540				11.01		
11.02	Speech Pathology	40420		8		11.02		
11.03	Speech Pathology	99952		16		11.03		
12	Medical Social Services	27500				12		
12.01	Medical Social Services	31540				12.01		
12.02	Medical Social Services	40420				12.02		
12.03	Medical Social Services	99952				12.03		
13	Home Health Aide	27500		128		13		
13.01	Home Health Aide	31540				13.01		
13.02	Home Health Aide	40420		6		13.02		
13.03	Home Health Aide	99952		4		13.03		
14	Total (sum of lines 8-13)			4,467		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	37,120		37,120			15
16	Cost of Drugs	9	26,402		26,402			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	0.267471			col. 2, line 2	1
2	Occupational Therapy	67	0.187048			col. 2, line 3	2

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	0.302285			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.129806			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.240783			col. 2, line 16	5

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 52-7075

WORKSHEET H-3
PARTS I & IICheck 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			Total Program Cost (sum of cols 9-10)	
	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	12	
1	Skilled Nursing Care		2,087			1,038,053		1,038,053	1
2	Physical Therapy		1,661			613,823		613,823	2
3	Occupational Therapy		523			216,433		216,433	3
4	Speech Pathology		58			13,314		13,314	4
5	Medical Social Services								5
6	Home Health Aide		138			8,067		8,067	6
7	Total (sum of lines 1-6)		4,467			1,889,690		1,889,690	7

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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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**

		Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	Description	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		824,461	11
12	Total PPS Reimbursement - Full Episodes with Outliers		17,903	12
13	Total PPS Reimbursement - LUPA Episodes		25,796	13
14	Total PPS Reimbursement - PEP Episodes		1,739	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		53,673	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)		923,572	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		923,572	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		923,572	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)		923,572	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		923,572	31
31.01	Sequestration adjustment (see instructions)		18,471	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		905,101	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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 52-7075

WORKSHEET H-5

	DESCRIPTION	Part A		Part B		
		mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider				905,101	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	Program	.01				3.01
	To	.02				3.02
	Provider	.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	To	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				905,101	4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	Program	.01				5.01
	To	.02				5.02
	Provider	.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

Health Financial Systems Compu-Max 2552-10

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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	949,135	Hours of Service	21,298.00	10.24	1
2	Licensed Practical Nurses	42,635	Hours of Service	1,673.00	0.80	2
3	Nurses Aides		Hours of Service			3
4	Technicians	545,311	Hours of Service	27,705.00	13.32	4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary	118,372	Accumulated Cost			8
9	Subtotal (sum of lines 1-8)	1,655,453				9
10	Employee Benefits	795,668	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	26,078	Percentage of Time			13
14	Supplies	1,073,938	Requisitions			14
15	Drugs	934,974	Requisitions			15
16	Other	149,305	Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*	4,635,416				17
18	Capital Related Costs-Bldgs. & Fixtures	133,592	Square Feet			18
19	Capital Related Costs-Mov. Equip.	20,003	Percentage of Time			19
20	Employee Benefits Department	559,181	Salary			20
21	Administrative and General	1,163,387	Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping	222,450	Square Feet			22
23	Medical Education Program Costs					23
24	Central Services & Supplies	162,046	Requisitions			24
25	Pharmacy	202,092	Requisitions			25
26	Other Allocated Costs	320,466	Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*	7,418,633				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)	7,418,633				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.

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	356,042	46,081	949,135	587,946	1,354,849	1,137,066	1
	MAINTENANCE							
2	Hemodialysis	168,102	21,824	449,478	278,436	641,619	538,483	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	152	19	401	245	577	484	6
7	CCPD	3,441	444	9,180	5,677	13,078	10,976	7
	HOME							
8	Hemodialysis							8
9	Intermittent Peritoneal							9
10	CAPD	13,410	1,733	35,696	22,114	50,968	42,776	10
11	CCPD	159,450	20,576	423,809	262,522	604,948	507,706	11
	OTHER BILLABLE SERVICES							
12	Inpatient Dialysis	11,487	1,485	30,571	18,952	43,659	36,641	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)	356,042	46,081	949,135	587,946	1,354,849	1,137,066	17
18	Medical Educational Program Costs							18
19	Total Renal Costs (line 17 + line 18)							19

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	1,235,984		5,667,103	1,751,530	7,418,633	1
	MAINTENANCE						
2	Hemodialysis	585,327		2,683,269	829,318	3,512,587	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	527		2,405	743	3,148	6
7	CCPD	11,931		54,727	16,914	71,641	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	46,496		213,193	65,892	279,085	10
11	CCPD	551,874		2,530,885	782,221	3,313,106	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis	39,829		182,624	56,444	239,068	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)	1,235,984		5,667,103	1,751,530	7,418,633	17
18	Medical Educational Program Costs						18
19	Total Renal Costs (line 17 + line 18)					7,418,633	19

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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

		CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT (Salary)	
		BUILDING (Square Feet)	EQUIPMENT (% of Time)	RNs (Hours)	OTHERS (Hours)		
	COMPOSITE PAYMENT SERVICES						
		1	2	3	4	5	
1	Total Renal Department Costs	356,042	46,081	949,135	587,946	1,354,849	1
	MAINTENANCE						
2	Hemodialysis	3,322	8,159.00	10,086.00	15,940.00	783,976	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	3	7.00	9.00	14.00	705	6
7	CCPD	68	166.00	206.00	325.00	15,980	7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	265	648.00	801.00	1,266.00	62,276	10
11	CCPD	3,151	7,692.00	9,510.00	15,029.00	739,169	11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 681	227	555.00	686.00	1,085.00	53,346	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	7,036	17,227.00	21,298.00	33,659.00	1,655,452	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	50.602899	2.674929	44.564513	17.467720	0.818416	18

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	1,137,066	1,235,984				1
	MAINTENANCE						
2	Hemodialysis	442,778	394,327				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	398	355				6
7	CCPD	9,025	8,038				7
	HOME						
8	Hemodialysis						8
9	Intermittent Peritoneal						9
10	CAPD	35,173	31,324				10
11	CCPD	417,471	371,790				11
	OTHER BILLABLE SERVICES						
12	Inpatient Dialysis Treatments 681	30,129	26,832				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	934,974	832,666			5,667,103	17
18	Unit Cost Multiplier (line 1 ÷ line 17)	1.216147	1.484369			0.309070	18

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

Check applicable box: ☒ Renal Dialysis Department ☐ Home Program Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments	Number of Program Treatments	Total Program Expenses (see instructions)	
		1	2	3	4	4.01	4.02	5	
1	Maintenance - Hemodialysis	10,008	3,512,587	350.98	7,050			2,474,409	1
2	Maintenance - Peritoneal Dialysis								2
3	Training - Hemodialysis								3
4	Training - Peritoneal Dialysis								4
5	Training - Continuous Ambulatory Peritoneal Dialysis	9	3,148	349.78	1			350	5
6	Training - Continuous Cycling Peritoneal Dialysis	204	71,641	351.18	55			19,315	6
7	Home Program - Hemodialysis	795			348				7
8	Home Program - Peritoneal Dialysis	9,436			4,649				8
		Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks		
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	139	279,085	2,007.81	52			104,406	9
10	Home Program - Continuous Cycling Peritoneal Dialysis	1,430	3,313,106	2,316.86	718			1,663,505	10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	20,452	7,179,567		12,103			4,261,985	11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)	25,159							12

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	1,672,526			237.24			1
2	Maintenance - Peritoneal Dialysis							2
3	Training - Hemodialysis							3
4	Training - Peritoneal Dialysis							4
5	Training - Continuous Ambulatory Peritoneal Dialysis	303			303.00			5
6	Training - Continuous Cycling Peritoneal Dialysis	12,608			229.24			6
7	Home Program - Hemodialysis							7
8	Home Program - Peritoneal Dialysis							8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	48,249			927.87			9
10	Home Program - COntinuous Cycling Peritoneal Dialysis	484,468			674.75			10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)	2,218,154						11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)							12

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)		4,261,985	1
		1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	2,218,154	2,218,154	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)	2,218,154	2,218,154	2.03
2.04	Outlier payments			2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)	250	250	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)	250	250	3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)	443,581	443,581	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)	443,581	443,581	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)		443,831	8
9	Program payment (see instructions)		1,774,323	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)		7,179,567	12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)		7,179,567	13
14	Facility specific composite cost percentage (line 13 divided by line 12)		1.000000	14

Health Financial Systems Compu-Max 2552-10

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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 52-0100****WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,263,602	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	98,067	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)	43,59	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)	1,361,669	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

Health Financial Systems Compu-Max 2552-10

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	OTHER ANCILLARY							76
76.01	SLEEP/EEG							76.01
76.02	GI							76.02
76.03	NUCLEAR MED							76.03
76.04	PSYCH							76.04
76.05	ULTRASOUND							76.05
76.06	VASCULAR LAB							76.06
76.07	MEDICAL OUTPATIENT							76.07
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	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
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	PATHOLOGY							194
194.01	PHYSIATRY CLINIC							194.01
194.02	JANESVILLE MED CENTER							194.02
194.03	OCCUPATIONAL HEALTH AND WELLNESS							194.03

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		
194.04	ASSISTED LIVING CENTERS							194.04
194.05	NORTHPOINTE FITNESS & SPA CENTER							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

Health Financial Systems Compu-Max 2552-10

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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		216,033	216,033		216,033		216,033	3
4	Administrative & General	347,538	141,825	489,363		489,363	-269,705	219,658	4
5	Plant Operation & Maintenance		157,041	157,041		157,041	-95,430	61,611	5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies								10
11	Medical Records	37,833		37,833		37,833		37,833	11
12	Staff Transportation		74,467	74,467		74,467		74,467	12
13	Volunteer Service Coordination	34,972		34,972		34,972		34,972	13
14	Pharmacy		217,141	217,141		217,141		217,141	14
15	Physician Administrative Services								15
16	Other General Service								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	106,935		106,935		106,935		106,935	27
28	Registered Nurse	958,009		958,009		958,009		958,009	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	176,165		176,165		176,165		176,165	33
34	Spiritual Counseling	112,580		112,580		112,580		112,580	34
35	Dietary Counseling								35
36	Counseling - Other	54,463		54,463		54,463		54,463	36
37	Hospice Aide and Homemaker Services	215,161		215,161		215,161		215,161	37
38	Durable Medical Equipment - Oxygen		106,265	106,265		106,265		106,265	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		393,351	393,351		393,351		393,351	41
42	Medical Supplies - Non-routine		215,751	215,751		215,751		215,751	42
42.50	Drugs Charged to Patients								42.50
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	2,754		2,754		2,754		2,754	62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program	159,757	5,891	165,648		165,648		165,648	64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising	1,603	29,779	31,382		31,382		31,382	67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
100	TOTAL	2,207,770	1,557,544	3,765,314		3,765,314	-365,135	3,400,179	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	106,935		106,935		106,935		106,935	27
28	Registered Nurse	958,009		958,009		958,009		958,009	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	176,165		176,165		176,165		176,165	33
34	Spiritual Counseling	112,580		112,580		112,580		112,580	34
35	Dietary Counseling								35
36	Counseling - Other	54,463		54,463		54,463		54,463	36
37	Hospice Aide and Homemaker Services	215,161		215,161		215,161		215,161	37
38	Durable Medical Equipment - Oxygen		106,265	106,265		106,265		106,265	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		393,351	393,351		393,351		393,351	41
42	Medical Supplies - Non-routine		215,751	215,751		215,751		215,751	42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1,623,313	715,367	2,338,680		2,338,680		2,338,680	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		75,722	75,722	1
2	Cap Rel Costs-Mvble Equip		17,293	17,293	2
3	Employee Benefits Department	216,033	745,743	961,776	3
4	Administrative & General	219,658	922,092	1,141,750	4
5	Plant Operation & Maintenance	61,611	101,343	162,954	5
6	Laundry & Linen Service				6
7	Housekeeping		24,744	24,744	7
8	Dietary				8
9	Nursing Administration				9
10	Routine Medical Supplies		4,506	4,506	10
11	Medical Records	37,833	26,117	63,950	11
12	Staff Transportation	74,467		74,467	12
13	Volunteer Service Coordination	34,972		34,972	13
14	Pharmacy	217,141	412	217,553	14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care	2,338,680		2,338,680	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	2,754		2,754	62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program	165,648		165,648	64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising	31,382		31,382	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	3,400,179	1,917,972	5,318,151	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	75,722	75,722						1
2	Cap Rel Costs-Mvble Equip	17,293		17,293					2
3	Employee Benefits Department	961,776			961,776				3
4	Administrative & General	1,141,750	75,722	17,293	151,399	1,386,164	1,386,164		4
5	Plant Operation & Maintenance	162,954				162,954	57,447	220,401	5
6	Laundry & Linen Service								6
7	Housekeeping	24,744				24,744	8,723		7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies	4,506				4,506	1,589		10
11	Medical Records	63,950			16,481	80,431	28,355		11
12	Staff Transportation	74,467				74,467	26,252		12
13	Volunteer Service Coordination	34,972			15,235	50,207	17,700		13
14	Pharmacy	217,553				217,553	76,695		14
15	Physician Administrative Services								15
16	Other General Service							220,401	16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care	2,338,680			707,168	3,045,848	1,073,769		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	2,754			1,200	3,954	1,394		62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program	165,648			69,595	235,243	82,931		64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising	31,382			698	32,080	11,309		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	5,318,151	75,722	17,293	961,776	5,318,151	1,386,164	220,401	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

HOSPICE CCN: 52-1525

WORKSHEET O-6 PART I

	Descriptions	LAUNDRY & LINEN 6	HOUSE-KEEPING 7	DIETARY 8	NURSING ADMINIS-TRATION 9	ROUTINE MEDICAL SUPPLIES 10	MEDICAL RECORDS 11	STAFF TRANS-PORTATION 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		33,467						7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies					6,095			10
11	Medical Records						108,786		11
12	Staff Transportation							100,719	12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service		33,467						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care					6,095	108,786	100,719	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		33,467			6,095	108,786	100,719	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	67,907						13
14	Pharmacy		294,248					14
15	Physician Administrative Services							15
16	Other General Service				253,868			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care							50
51	Hospice Routine Home Care	67,907	294,248		253,868		4,951,240	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						5,348	62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program						318,174	64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising						43,389	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	67,907	294,248		253,868		5,318,151	100

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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		14,894						2
3	Employee Benefits Department			2,207,770					3
4	Administrative & General	4,000	14,894	347,538	-1,386,164	3,931,987			4
5	Plant Operation & Maintenance					162,954	4,000		5
6	Laundry & Linen Service								6
7	Housekeeping					24,744			7
8	Dietary								8
9	Nursing Administration								9
10	Routine Medical Supplies					4,506			10
11	Medical Records			37,833		80,431			11
12	Staff Transportation					74,467			12
13	Volunteer Service Coordination			34,972		50,207			13
14	Pharmacy					217,553			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			1,623,313		3,045,848			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			2,754		3,954			62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program			159,757		235,243			64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising			1,603		32,080			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)	75,722	17,293	961,776		1,386,164	220,401		100
101	Unit cost multiplier	18.930500	1.161072	0.435632		0.352535	55.100250		101

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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 7	DIETARY IN-FACILITY DAYS 8	NURSING ADMINISTRATION DIRECT NURS. HRS. 9	ROUTINE MEDICAL SUPPLIES PATIENT DAYS 10	MEDICAL RECORDS PATIENT DAYS 11	STAFF TRANSPORTATION MILEAGE 12	VOLUNTEER SVC COORDINATION HOURS OF SERVICE 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				22,811				10
11	Medical Records					22,811			11
12	Staff Transportation						144,000		12
13	Volunteer Service Coordination							1,435	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				22,811	22,811	144,000	1,435	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)	33,467			6,095	108,786	100,719	67,907	100
101	Unit cost multiplier	8.366750			0.267196	4.769015	0.699438	47.321951	101

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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	4,299,117				14
15	Physician Administrative Services					15
16	Other General Service			253,868		16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care					50
51	Hospice Routine Home Care	4,299,117		253,868		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)	294,248		253,868		100
101	Unit cost multiplier	0.068444		1.000000		101

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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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)					
	Cost Center Descriptions	Wkst C Pt I, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP	
		0	1	2	3	4	5	
AN C	ANCILLARY SERVICE COST CENTERS	0						AN C
1	Physical Therapy	66	0.267471					1
2	Occupational Therapy	67	0.187048					2
3	Speech Language Pathology	68	0.302285					3
4	Drugs, Biological & Infusion Therapy	73	0.240783					4
5	Durable Medical Equipment/Oxygen	96						5
6	Labs and Diagnostics	60	0.137306					6
7	Medical Supplies	71	0.129806					7
8	Outpatient Services (incl E/R)	93						8
9	Radiation Therapy	55	0.104389					9
10	Other	76						10
11	Totals (sum of lines 1-10)	0						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	
AN C	ANCILLARY SERVICE COST CENTERS					AN C
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

Health Financial Systems Compu-Max 2552-10

BELOIT MEMORIAL HOSPITAL, INC. Provider CCN: 52-0100	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 08/21/2020 Run Time: 11:32 Version: 2020.06 (08/17/2020)
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CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

HOSPICE CCN: 52-1525

WORKSHEET O-8

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	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			4,951,240	6
7	Total unduplicated days			22,811	7
8	Total average cost per diem			217.05	8
9	Unduplicated program days	21,293	95		9
10	Program cost	4,621,646	20,620		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			4,951,240	21
22	Total unduplicated days			22,811	22
23	Average cost per diem			217.05	23