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Health Financial Systems

MIWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/12/2018 1:39 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/12/2018	Time: 1:39 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4	12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

Encryption Information

ECR: Date: 2/12/2018 Time: 1:39 pm
 xq5naAxGHMYWvtXE8P4RN: 73Tl aJ: 0
 B42Na02WJwJocNtJh2Atg. p5Q0aK8U
 VFk: 1. EVp20XfUJG

PI: Date: 2/12/2018 Time: 1:39 pm
 4xFucfnk110wgSmggeX6MQG1Vs9Rb0
 Ij a2rOfxBj l38ZQVdi cl sYde5E4RCb
 I4An00ta0s0Vbz1P

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-46,986	340,970	1	0 1.00
2.00	Subprovider - IPF	0	0	0		0 2.00
3.00	Subprovider - IRF	0	0	0		0 3.00
4.00	SUBPROVIDER I					0 4.00
5.00	Swing bed - SNF	0	-141,449	0		0 5.00
6.00	Swing bed - NF	0				0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0 7.00
10.00	RURAL HEALTH CLINIC I	0		679		0 10.00
10.01	RURAL HEALTH CLINIC II	0		-3,029		0 10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0 11.00
200.00	Total	0	-188,435	338,620	1	0 200.00

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 and review the 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 the 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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In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302			Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/12/2018 1:26 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 MEDICAL CENTER DRIVE			PO Box:						1.00	
2.00	City: GALENA			State: IL		Zip Code: 61036-		County: JO DAVI ESS		2.00	
Hospital and Hospital Health Care Complex Component Identification:											
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00	Hospital		MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		MIDWEST MEDICAL CENTER	14Z302	99914		02/01/2000	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II		MIDWEST HEALTH CLINIC OF ELIZABETH	148557	99914		07/15/2016	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2016	09/30/2017		20.00		
21.00	Type of Control (see instructions)					2			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, 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 Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00		
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		22.03		
23.00	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.						2		23.00		
						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
						1.00	2.00	3.00	4.00	5.00	6.00
24.00	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.					0	0	0	0	0	0

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/12/2018 1:26 pm				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the 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.	0	0	0	0	0	0	25.00		
						Urban/Rural	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2	26.00		
27.00	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	27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0	35.00		
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0	37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						N	37.01		
38.00	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.							38.00		
						Y/N	Y/N			
						1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	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	40.00	
						V	XVIII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)						N			60.00
		Y/N	IME	Direct GME	IME	Direct GME				
		1.00	2.00	3.00	4.00	5.00				
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00			
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)		0.00	0.00			61.01			

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-2
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
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)		0.00	0.00			61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 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)				0.00		62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N		63.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	1.00	2.00	3.00	4.00	5.00	
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.						
64.00 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)			0.00	0.00	0.000000	64.00
	Program Name		Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
	1.00	2.00	3.00	4.00	5.00	

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Provider CCN: 14-1302

Period:
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To 09/30/2017

Worksheet S-2
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	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)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	

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		1.00	2.00	3.00		
76.00	If line 75 yes: Column 1: Did the facility have an approved GME 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0		76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	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		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		90.00
91.00	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		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y		92.00
93.00	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		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?		Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y			108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	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 no for each therapy.	N	Y	Y	N	109.00
		1.00				
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	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, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/12/2018 1:26 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	184,419	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	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	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.04	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	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		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
		1.00	2.00		
145.00	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	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "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		146.00
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	149.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/12/2018 1:26 pm		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00			
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)								
155.00	Hospital	Y	Y	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
161.10	CORF		N	N	N		161.10	
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00	
168.00	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)						168.00	
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	
169.00	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)						169.00	
		Beginning 1.00		Ending 2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2016	09/30/2017		170.00	
		1.00		2.00				
171.00	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 yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N			171.00	

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part II Date/Time Prepared: 2/12/2018 1:26 pm	
		Y/N	Date			1.00	2.00
<p>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</p> <p>COMPLETED BY ALL HOSPITALS</p> <p>Provider Organization and Operation</p>							
1.00	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					1.00
		Y/N	Date	V/I			
2.00	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					2.00
3.00	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					3.00
		Y/N	Type	Date			
4.00	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	01/10/2018			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N	1.00				
<p>Approved Educational Activities</p>							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
<p>Bed Complement</p>							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
<p>PS&R Data</p>							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/23/2018	Y	01/23/2018		17.00
18.00	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 this cost report? If yes, see instructions.	N		N			18.00
19.00	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			19.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-2
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
						1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	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			Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		34.00
35.00	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.			N		35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	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.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
						1.00
						2.00
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL			TRACZEK	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586619			PTRACZEK@WI PFLI . COM	43.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-2
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

	3.00	
Cost Report Preparer Contact Information		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	41.00
42.00	Enter the employer/company name of the cost report preparer.	42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	43.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 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)	30.00	25	9,125	11,606.40	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	11,606.40	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	11,606.40	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,825		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	18,980			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 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)	287	21	351			1.00
2.00 HMO and other (see instructions)	6	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,268	0	1,533			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	112			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,555	21	1,996			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,555	21	1,996	0.00	92.18	14.00
15.00 CAH visits	5,062	0	22,498			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	3.23	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			18,371	0.00	45.82	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	2,755	0	9,189	0.00	13.87	26.00
26.01 RURAL HEALTH CLINIC II	172	0	2,600	0.00	3.97	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	159.07	27.00
28.00 Observation Bed Days		0	90			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	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)		0	101	10	130	1.00
2.00	HMO and other (see instructions)			2	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	101	10	130	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				32	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-7

Date/Time Prepared:
2/12/2018 1:26 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	02/01/2000		2.00
		1.00	2.00	3.00	4.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	25	0	25 21.00
22.00		RMB	14	0	14 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-7

Date/Time Prepared:
2/12/2018 1:26 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		39	0	39	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		99914	0	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
<p>A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)</p>						
202.00	Staffing		1,204,040	0.00	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302
Component CCN: 14-8511

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8
Date/Time Prepared:
2/12/2018 1:26 pm

		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification Street	ONE MEDICAL CENTER DRIVE			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GALENA IL		61036	2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
4.00	Source of Federal Funds				4.00
5.00	Community Health Center (Section 330(d), PHS Act)				5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)				6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				7.00
8.00	Appalachian Regional Commission				8.00
9.00	Look-Alikes				9.00
9.01	OTHER (SPECIFY)				9.01
9.02					9.02
9.03					9.03
9.04					9.04
9.05					9.05
9.06					9.06
9.07					9.07
9.08					9.08
9.09					9.09
9.10					9.10
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N			0 10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday			
		from			
11.00	Facility hours of operations (1) Clinic	07:30		17:00	07:30 11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N			0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits			5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302
Component CCN: 14-8511

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8
Date/Time Prepared:
2/12/2018 1:26 pm

		RHC I		Cost	
		County			
		4.00			
2.00	City, State, ZIP Code, County	JO DAVI ESS			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	Clinic	17:00	07:30	17:00	07:30
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	Clinic	07:30	17:00	08:00	12:00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302
Component CCN: 14-8557

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8
Date/Time Prepared:
2/12/2018 1:26 pm

		RHC II		Cost			
		1.00					
1.00	Clinic Address and Identification Street	560 PLEASANT STREET		1.00			
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	ELIZABETH IL		2.00			
		1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00		
		Grant Award		Date			
		1.00		2.00			
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)			4.00			
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00			
7.00	Appalachian Regional Commission			7.00			
8.00	Look-Alikes			8.00			
9.00	OTHER (SPECIFY)			9.00			
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00		
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1) Clinic	08:00		17:00	08:00		
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number			Total Visits		14.00	
		Y/N	V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County					
		4.00					
2.00	City, State, ZIP Code, County	JO DAVI ESS				2.00	
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1) Clinic	17:00	08:00	17:00	08:00	17:00	11.00

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Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017		Worksheet S-8
		Component CCN: 14-8557			Date/Time Prepared: 2/12/2018 1:26 pm
				RHC II	Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet S-10 Date/Time Prepared: 2/12/2018 1:26 pm
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.790922	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			3,280,177	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			5,907,511	6.00	
7.00	Medicaid cost (line 1 times line 6)			4,672,380	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,392,203	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,392,203	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	134,742	0	134,742	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	106,570	0	106,570	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	106,570	0	106,570	23.00	
				1.00		
24.00	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	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,071,233	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			27,021	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			41,572	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			1,029,661	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			828,933	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			935,503	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,327,706	31.00	

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,569,642		1,569,642	-1,521,219	48,423	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0		0	83,064	83,064	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0		0	4,059,871	4,059,871	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		0		0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		856,331		856,331	-821,360	34,971	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0		0	1,218,162	1,218,162	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,311,802		2,311,802	-116,695	2,195,107	4.00
5.01	00570	ADMINISTRATIVE	243,343	3,842		247,185	0	247,185	5.01
5.02	00550	INFORMATION TECHNOLOGY	271,953	274,673		546,626	0	546,626	5.02
5.03	00590	HOSPITAL BILLING	0	0		0	255,624	255,624	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	499,620	1,185,134		1,684,754	-379,440	1,305,314	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0		0	0	0	6.00
7.00	00700	OPERATION OF PLANT	79,807	503,414		583,221	0	583,221	7.00
7.01	00701	OPERATION OF PLANT-SCC	75,079	210,762		285,841	0	285,841	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,694		48,694	-29,899	18,795	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	31,900		31,900	29,899	61,799	8.01
9.00	00900	HOUSEKEEPING	110,192	32,748		142,940	0	142,940	9.00
9.01	00901	HOUSEKEEPING-SCC	80,743	17,939		98,682	0	98,682	9.01
10.00	01000	DIETARY	180,175	164,038		344,213	0	344,213	10.00
10.01	01001	DIETARY-SCC	220,075	234,205		454,280	81,529	535,809	10.01
11.00	01100	CAFETERIA	0	0		0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0		0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	216,155	3,016		219,171	31,811	250,982	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	71,782	1,662		73,444	0	73,444	14.00
15.00	01500	PHARMACY	0	0		0	81,000	81,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,297	15,520		165,817	0	165,817	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	720,406	83,760		804,166	170,805	974,971	30.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0		0	12,361	12,361	44.00
46.00	04600	OTHER LONG TERM CARE	1,327,751	333,569		1,661,320	103,962	1,765,282	46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	169,922	172,960		342,882	63,487	406,369	50.00
53.00	05300	ANESTHESIOLOGY	192,583	27,815		220,398	0	220,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,001	788,553		1,091,554	8,296	1,099,850	54.00
57.00	05700	CT SCAN	0	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	0	0	59.00
60.00	06000	LABORATORY	280,197	371,352		651,549	0	651,549	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	20,945		20,945	0	20,945	64.00
65.00	06500	RESPIRATORY THERAPY	0	50,855		50,855	-52,607	-1,752	65.00
66.00	06600	PHYSICAL THERAPY	972,376	103,143		1,075,519	-36,960	1,038,559	66.00
66.01	06601	CARDIAC REHAB	0	0		0	52,607	52,607	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	91,478		91,478	22,551	114,029	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,154		25,154	0	25,154	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,019		62,019	0	62,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	359,513		359,513	-70,672	288,841	73.00
76.00	03020	SLEEP LAB	15,948	20,795		36,743	0	36,743	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		0	372	372	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	1,434,327	206,141		1,640,468	-65,182	1,575,286	88.00
88.01	08801	RURAL HEALTH CLINIC II	416,549	56,989		473,538	-52,279	421,259	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90.00	09000	CLINIC	0	171,808		171,808	-63,487	108,321	90.00
91.00	09100	EMERGENCY	305,169	1,555,002		1,860,171	0	1,860,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	2,969,761		2,969,761	-2,969,761	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,337,450	14,936,934	23,274,384	95,840	23,370,224	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	53,063	53,063	-42,619	10,444	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	232,688	110,198	342,886	-58,964	283,922	194.01
194.02	07952 ADULT DAY CARE	97,493	33,510	131,003	-8,666	122,337	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	14,409	14,409	194.05
200.00	TOTAL (SUM OF LINES 118-199)	8,667,631	15,133,705	23,801,336	0	23,801,336	200.00

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Health Financial Systems

MI DWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	48,423	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	83,064	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	-25,405	4,034,466	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	34,971	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-340,275	877,887	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,195,107	4.00
5.01	00570	ADMINISTRATIVE	0	247,185	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	546,626	5.02
5.03	00590	HOSPITAL BILLING	-30,525	225,099	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-226,799	1,078,515	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-33,938	549,283	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	285,841	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,795	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	61,799	8.01
9.00	00900	HOUSEKEEPING	0	142,940	9.00
9.01	00901	HOUSEKEEPING-SCC	0	98,682	9.01
10.00	01000	DIETARY	-80,298	263,915	10.00
10.01	01001	DIETARY-SCC	-181,243	354,566	10.01
11.00	01100	CAFETERIA	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	250,982	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	73,444	14.00
15.00	01500	PHARMACY	0	81,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,103	160,714	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,957	971,014	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	12,361	44.00
46.00	04600	OTHER LONG TERM CARE	-143,187	1,622,095	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-63,486	342,883	50.00
53.00	05300	ANESTHESIOLOGY	0	220,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-318,490	781,360	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	651,549	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	20,945	64.00
65.00	06500	RESPIRATORY THERAPY	0	-1,752	65.00
66.00	06600	PHYSICAL THERAPY	-10,500	1,028,059	66.00
66.01	06601	CARDIAC REHAB	0	52,607	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	114,029	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,154	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-37,854	250,987	73.00
76.00	03020	SLEEP LAB	0	36,743	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	372	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-29,978	1,545,308	88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,500	418,759	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-106,516	1,805	90.00
91.00	09100	EMERGENCY	-116,444	1,743,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,756,498	21,613,726	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,444	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	283,922	194.01
194.02	07952	ADULT DAY CARE	0	122,337	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	14,409	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,756,498	22,044,838	200.00

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Health Financial Systems
RECLASSIFICATIONS

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-6
Date/Time Prepared:
2/12/2018 1:26 pm

		Increases			
		Cost Center	Line #	Salary	Other
		2.00	3.00	4.00	5.00
A - RECLASS ADC AND ALU DIETARY EXPENSE					
1.00	DIETARY-SCC		10.01	0	81,529
2.00			0.00	0	0
	TOTALS			0	81,529
C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG		1.01	0	81,056
	TOTALS			0	81,056
D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	5,247
2.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	37,372
	TOTALS			0	42,619
E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY		44.00	0	12,361
2.00	OTHER LONG TERM CARE		46.00	0	128,561
	TOTALS			0	140,922
F - RECLASS PHARMACIST EXPENSE					
1.00	PHARMACY		15.00	0	81,000
	TOTALS			0	81,000
G - RECLASS PHYSICIAN HOSPITAL MED DIRECT					
1.00	ADULTS & PEDIATRICS		30.00	9,763	976
	TOTALS			9,763	976
H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	1,427,712
	TOTALS			0	1,427,712
I - RECLASS NEW HOSPITAL BOND AMORTIZATN					
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	33,333
	TOTALS			0	33,333
J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	0	822,944
	TOTALS			0	822,944
K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	2,571,584
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	0	388,399
	TOTALS			0	2,959,983
M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS		30.00	4,295	644
2.00			0.00	0	0
	TOTALS			4,295	644
P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC		88.00	0	89,100
2.00	RURAL HEALTH CLINIC II		88.01	0	27,595
	TOTALS			0	116,695
U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER		194.05	12,746	1,663
2.00	OCCUPATIONAL THERAPY		67.00	19,997	2,554
	TOTALS			32,743	4,217
X - RECLASS SURGEON FEES					
1.00	OPERATING ROOM		50.00	0	55,429
	TOTALS			0	55,429
Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS		3.00	0	41,034
	TOTALS			0	41,034
AA - RECLASS CLINIC MGR TIME TO HOSP/NH					
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	26,122	0
2.00	RURAL HEALTH CLINIC II		88.01	3,098	0
	TOTALS			29,220	0
BB - RECLASS SR CARE ADMINISTRATOR TIME					
1.00	ASSISTED LIVING UNITS		194.01	10,791	0
2.00	ADULT DAY CARE		194.02	3,108	0
	TOTALS			13,899	0
DD - RECLASS NURSE PRACTITIONER MGMT TIME					
1.00	NURSING ADMINISTRATION		13.00	29,820	1,991
	TOTALS			29,820	1,991

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-6

Date/Time Prepared:
2/12/2018 1:26 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC		8.01	0	29,899	1.00
	TOTALS			0	29,899	
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	10,328	1.00
2.00	SNF PHYSICAL THERAPY - SCC		76.02	372	0	2.00
	THERAPY					
	TOTALS			372	10,328	
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	ADULTS & PEDIATRICS		30.00	74,250	7,057	1.00
	TOTALS			74,250	7,057	
JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC		54.00	0	8,296	1.00
2.00	RURAL HEALTH CLINIC		88.00	0	1,482	2.00
	TOTALS			0	9,778	
KK - RECLASS ELIZABETH CLINIC DEPR						
1.00	RURAL HEALTH CLINIC II		88.01	0	25,118	1.00
	TOTALS			0	25,118	
MM - RECLASS CLINIC MD SALARY						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	32,018	0	1.00
2.00	ADULTS & PEDIATRICS		30.00	73,820	0	2.00
3.00	RURAL HEALTH CLINIC		88.00	1,271	0	3.00
	TOTALS			107,109	0	
NN - ENT MD TIME IN OR						
1.00	OPERATING ROOM		50.00	0	8,058	1.00
	TOTALS			0	8,058	
PP - RECLASS HOSPITAL BILLING EXPENSES						
1.00	HOSPITAL BILLING		5.03	0	255,624	1.00
	TOTALS			0	255,624	
QQ - RECLASS CARDIAC REHAB EXP						
1.00	CARDIAC REHAB		66.01	25,277	27,330	1.00
	TOTALS			25,277	27,330	
500.00	Grand Total: Increases			326,748	6,265,276	500.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-6
Date/Time Prepared:
2/12/2018 1:26 pm

		Decreases					
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
6.00	7.00			8.00	9.00	10.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE							
1.00		ADULT DAY CARE	194.02	0	11,774	0	1.00
2.00		ASSISTED LIVING UNITS	194.01	0	69,755	0	2.00
		TOTALS		0	81,529		
C - RECLASS ASSISTED LIVING BUILDING DEP							
1.00		NEW CAP REL COSTS-BLDG & FIXT	1.00	0	81,056	9	1.00
		TOTALS		0	81,056		
D - RECLASS PT/MOB SPACE DEPRECIATION							
1.00		PHYSICIANS' PRIVATE OFFICES	192.00	0	5,247	9	1.00
2.00		PHYSICIANS' PRIVATE OFFICES	192.00	0	37,372	9	2.00
		TOTALS		0	42,619		
E - RECLASS NURSING HOME ADMIN AND GEN							
1.00		OTHER ADMINISTRATIVE AND GENERAL	5.04	0	140,922	0	1.00
2.00			0.00	0	0	0	2.00
		TOTALS		0	140,922		
F - RECLASS PHARMACIST EXPENSE							
1.00		DRUGS CHARGED TO PATIENTS	73.00	0	81,000	0	1.00
		TOTALS		0	81,000		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT							
1.00		RURAL HEALTH CLINIC	88.00	9,763	976	0	1.00
		TOTALS		9,763	976		
H - RECLASS NEW HOSPITAL DEPRECIATION							
1.00		NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,427,712	9	1.00
		TOTALS		0	1,427,712		
I - RECLASS NEW HOSPITAL BOND AMORTIZATN							
1.00		NEW CAP REL COSTS-BLDG & FIXT	1.00	0	33,333	9	1.00
		TOTALS		0	33,333		
J - RECLASS NEW HOSPITAL MME DEPRECIATN							
1.00		NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	822,944	9	1.00
		TOTALS		0	822,944		
K - RECLASS INTEREST EXPENSE - NEW HOSP							
1.00		INTEREST EXPENSE	113.00	0	2,959,983	11	1.00
2.00			0.00	0	0	11	2.00
		TOTALS		0	2,959,983		
M - RECLASS PHYSICIAN IP ROUND TIME							
1.00		RURAL HEALTH CLINIC	88.00	3,442	516	0	1.00
2.00		RURAL HEALTH CLINIC II	88.01	853	128	0	2.00
		TOTALS		4,295	644		
P - RECLASS PHYSICIAN BENEFITS							
1.00		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	116,695	0	1.00
2.00			0.00	0	0	0	2.00
		TOTALS		0	116,695		
U - RECLASS COMMUNITY FITNESS CTR USE							
1.00		PHYSICAL THERAPY	66.00	32,743	4,217	0	1.00
2.00			0.00	0	0	0	2.00
		TOTALS		32,743	4,217		
X - RECLASS SURGEON FEES							
1.00		CLINIC	90.00	0	55,429	0	1.00
		TOTALS		0	55,429		
Y - RECLASS PROPERTY INSURANCE EXP							
1.00		OTHER ADMINISTRATIVE AND GENERAL	5.04	0	41,034	12	1.00
		TOTALS		0	41,034		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00		RURAL HEALTH CLINIC	88.00	29,220	0	0	1.00
2.00			0.00	0	0	0	2.00
		TOTALS		29,220	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00		OTHER LONG TERM CARE	46.00	13,899	0	0	1.00
2.00			0.00	0	0	0	2.00
		TOTALS		13,899	0		
DD - RECLASS NURSE PRACTITIONER MGMT TIME							
1.00		RURAL HEALTH CLINIC	88.00	29,820	1,991	0	1.00
		TOTALS		29,820	1,991		
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY							
1.00		LAUNDRY & LINEN SERVICE	8.00	0	29,899	0	1.00
		TOTALS		0	29,899		

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Health Financial Systems
RECLASSIFICATIONS

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-6

Date/Time Prepared:
2/12/2018 1:26 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE	46.00	372	10,328	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		372	10,328			
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC	88.00	74,250	7,057	0		1.00
	TOTALS		74,250	7,057			
JJ - RECLASS CAP LEASE INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	9,778	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	9,778			
KK - RECLASS ELIZABETH CLINIC DEPR							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,118	9		1.00
	TOTALS		0	25,118			
MM - RECLASS CLINIC MD SALARY							
1.00	RURAL HEALTH CLINIC II	88.01	107,109	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		107,109	0			
NN - ENT MD TIME IN OR CLINIC							
1.00	CLINIC	90.00	0	8,058	0		1.00
	TOTALS		0	8,058			
PP - RECLASS HOSPITAL BILLING EXPENSES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	255,624	0		1.00
	TOTALS		0	255,624			
QQ - RECLASS CARDIAC REHAB EXP							
1.00	RESPIRATORY THERAPY	65.00	25,277	27,330	0		1.00
	TOTALS		25,277	27,330			
500.00	Grand Total: Decreases		326,748	6,265,276			500.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	448,597	0	0	0	1.00	
2.00	Land Improvements	3,740,814	18,430	0	18,430	2.00	
3.00	Buildings and Fixtures	38,287,471	136,670	0	136,670	3.00	
4.00	Building Improvements	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	5.00	
6.00	Movable Equipment	7,807,276	495,543	0	495,543	6.00	
7.00	HIT designated Assets	2,556,630	23,500	0	23,500	7.00	
8.00	Subtotal (sum of lines 1-7)	52,840,788	674,143	0	674,143	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	52,840,788	674,143	0	674,143	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	448,597	0			1.00	
2.00	Land Improvements	3,759,244	0			2.00	
3.00	Buildings and Fixtures	38,424,141	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	8,281,993	0			6.00	
7.00	HIT designated Assets	2,580,130	0			7.00	
8.00	Subtotal (sum of lines 1-7)	53,494,105	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	53,494,105	0			10.00	

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,569,642	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	856,331	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,425,973	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,569,642				1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0				1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	856,331				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,425,973				3.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,371,340	0	4,371,340	0.082407	3,381	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	2,596,083	0	2,596,083	0.048941	2,008	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,215,962	0	35,215,962	0.663883	27,242	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,047,530	0	2,047,530	0.038599	1,584	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	8,814,591	0	8,814,591	0.166170	6,819	2.01
3.00	Total (sum of lines 1-2)	53,045,506	0	53,045,506	1.000000	41,034	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	3,381	45,042	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,008	81,056	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	27,242	1,461,045	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1,584	33,387	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	6,819	486,506	0	2.01
3.00	Total (sum of lines 1-2)	0	0	41,034	2,107,036	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,381	0	0	48,423	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,008	0	0	83,064	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	2,546,179	27,242	0	0	4,034,466	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,584	0	0	34,971	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	384,562	6,819	0	0	877,887	2.01
3.00	Total (sum of lines 1-2)	2,930,741	41,034	0	0	5,078,811	3.00

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Health Financial Systems
ADJUSTMENTS TO EXPENSES

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			ONEW CAP REL COSTS-ALU BLDG	1.01	0	1.01
1.02 Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	B	-25,405	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	1.02
1.03 Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			ONEW CAP REL COSTS-2007 MOB	1.03	0	1.03
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-3,837	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	11	2.01
3.00 Investment income - other (chapter 2)	B	-82	RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-6,098	OPERATION OF PLANT	7.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-608,811			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-80,298	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-5,103	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		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 #		
1.00	2.00	3.00	4.00	5.00			
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG			NEW CAP REL COSTS-ALU BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB			NEW CAP REL COSTS-2007 MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	27.01
28.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-336,438	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0	0	0.00	0	33.00
33.01	INTEREST INCOME	B	-15	RURAL HEALTH CLINIC	88.00	0	33.01
33.05	PROVIDER RHC REVENUE	B	-18,400	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PART B BILLING COSTS	A	-30,525	HOSPITAL BILLING	5.03	0	33.06
33.07	SCHOOL ATHLETIC TRAINING REVENUE	B	-10,500	PHYSICAL THERAPY	66.00	0	33.07
33.08	HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-145,564	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	MARKETING EXPENSES - NONALLOW	A	-70,192	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	A	-7,893	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	A	-3,150	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NH BED ASSESSMENT	A	-143,187	OTHER LONG TERM CARE	46.00	0	36.00
37.00			0	0	0.00	0	37.00
38.00	MISC REVENUE - SCHOOL NURSE	B	-2,500	RURAL HEALTH CLINIC II	88.01	0	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	B	-91,626	DIETARY-SCC	10.01	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-89,617	DIETARY-SCC	10.01	0	41.00
42.00	RHC PROVIDER OR TIME	A	-11,563	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	SLEEP AREA MISC RENTAL INCOME	B	-27,840	OPERATION OF PLANT	7.00	0	43.00
43.01	PHARMACY CONTRACT PROG EXPENSE	A	-37,854	DRUGS CHARGED TO PATIENTS	73.00	0	43.01
43.02			0	0	0.00	0	43.02
43.03			0	0	0.00	0	43.03
43.04			0	0	0.00	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,756,498				50.00

(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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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8-2

Date/Time Prepared:
2/12/2018 1:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,369,928	116,444	1,253,484	0	0	1.00
2.00	60.00	LABORATORY	9,957	0	9,957	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	318,409	318,408	1	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	3,958	3,957	1	0	0	4.00
5.00	50.00	OPERATING ROOM	63,487	63,486	1	0	0	5.00
6.00	90.00	CLINIC	106,517	106,516	1	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,872,256	608,811	1,263,445			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	116,444		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	318,408		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,957		4.00
5.00	50.00	OPERATING ROOM	0	0	0	63,486		5.00
6.00	90.00	CLINIC	0	0	0	106,516		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	608,811		200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/12/2018 1:26 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					62	1.00
2.00	Line 1 multiplied by 15 hours per week					930	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					185	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,114.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.95	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.48	38.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	264	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	8,094	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					85,784	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					85,784	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					85,784	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					85,784	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					7,119	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,119	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,027	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,146	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					20,315	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					20,315	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					4,533	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,146	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/12/2018 1:26 pm
		Occupational Therapy	Cost

	1.00	
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00
	Therapists	Assistants
	1.00	2.00
	Aides	Trainees
	3.00	4.00
	Total	5.00

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.95	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)	85,784	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,146	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	93,930	63.00
64.00	Total cost of outside supplier services (from your records)	91,478	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,119	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,027	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,146	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,027	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	20,315	101.01
101.02	Line 34 = sum of lines 27 and 31	21,342	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	20,315	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	4,533	102.01
102.02	Line 35 = sum of lines 31 and 32	24,848	102.02

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/12/2018 1:26 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					21	1.00
2.00	Line 1 multiplied by 15 hours per week					315	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					63	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	376.53	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.97	36.97	0.00			11.00
12.00	Number of travel hours (provider site)	0	46	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	2,789	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					27,841	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					27,841	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					27,841	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					27,841	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,329	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,329	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					350	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,679	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					3,401	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					3,401	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					1,562	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,679	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/12/2018 1:26 pm
		Speech Pathology	Cost
			1.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0 46.00
		Therapists Assistants Aides Trainees	Total
		1.00 2.00 3.00 4.00	5.00
PART V - OVERTIME COMPUTATION			
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00
48.00	Overtime rate (see instructions)	0.00	0.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00
CALCULATION OF LIMIT			
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00
DETERMINATION OF OVERTIME ALLOWANCE			
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.94	0.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0
			1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		27,841 57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		2,679 58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0 59.00
60.00	Overtime allowance (from column 5, line 56)		0 60.00
61.00	Equipment cost (see instructions)		0 61.00
62.00	Supplies (see instructions)		0 62.00
63.00	Total allowance (sum of lines 57-62)		30,520 63.00
64.00	Total cost of outside supplier services (from your records)		29,628 64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0 65.00
LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		2,329 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		350 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		2,679 100.02
LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		350 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		3,401 101.01
101.02	Line 34 = sum of lines 27 and 31		3,751 101.02
LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		3,401 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		1,562 102.01
102.02	Line 35 = sum of lines 31 and 32		4,963 102.02

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	48,423	48,423			1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	83,064	0	83,064		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	4,034,466	0	0	4,034,466	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	34,971				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	877,887				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,195,107	0	0	0	4.00
5.01	00570	ADMINISTRATIVE	247,185	0	0	58,311	5.01
5.02	00550	INFORMATION TECHNOLOGY	546,626	550	0	28,963	5.02
5.03	00590	HOSPITAL BILLING	225,099	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,078,515	7,199	24,974	349,942	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	549,283	0	0	271,373	7.00
7.01	00701	OPERATION OF PLANT-SCC	285,841	1,845	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	18,795	0	0	27,422	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	61,799	185	0	0	8.01
9.00	00900	HOUSEKEEPING	142,940	0	0	20,798	9.00
9.01	00901	HOUSEKEEPING-SCC	98,682	351	0	0	9.01
10.00	01000	DIETARY	263,915	0	0	246,955	10.00
10.01	01001	DIETARY-SCC	354,566	1,364	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	250,982	612	0	9,860	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	73,444	0	0	52,534	14.00
15.00	01500	PHARMACY	81,000	0	0	59,543	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,714	0	0	52,919	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	971,014	0	0	681,705	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	12,361	1,601	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	1,622,095	16,651	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	342,883	0	0	414,724	50.00
53.00	05300	ANESTHESIOLOGY	220,398	0	0	4,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	781,360	0	0	279,692	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	651,549	0	0	82,883	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	20,945	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-1,752	0	0	14,481	65.00
66.00	06600	PHYSICAL THERAPY	1,028,059	0	0	360,110	66.00
66.01	06601	CARDIAC REHAB	52,607	0	0	13,480	66.01
67.00	06700	OCCUPATIONAL THERAPY	114,029	0	0	28,655	67.00
68.00	06800	SPEECH PATHOLOGY	25,154	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,019	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,987	0	0	0	73.00
76.00	03020	SLEEP LAB	36,743	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	372	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,545,308	0	0	455,087	88.00
88.01	08801	RURAL HEALTH CLINIC II	418,759	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	1,805	0	0	46,217	90.00
91.00	09100	EMERGENCY	1,743,727	0	0	426,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB		
		0	1.00	1.01	1.02	1.03		
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,613,726	30,358	24,974	3,986,631	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22,878	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,444	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	283,922	0	53,741	0	0	194.01
194.02	07952	ADULT DAY CARE	122,337	0	4,349	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	18,065	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	14,409	0	0	24,957	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,044,838	48,423	83,064	4,034,466	0	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY		
		NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO					
		2.00	2.01					4.00
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02	
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	34,971				2.00	
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	877,887			2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,195,107		4.00	
5.01	00570	ADMITTING	0	0	75,028	380,524	5.01	
5.02	00550	INFORMATION TECHNOLOGY	0	42,707	83,849	0	5.02	
5.03	00590	HOSPITAL BILLING	0	0	0	0	5.03	
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	555	165,109	171,970	0	5.04	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	0	39,318	24,606	0	7.00	
7.01	00701	OPERATION OF PLANT-SCC	3,023	0	23,149	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,731	0	0	8.00	
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	8.01	
9.00	00900	HOUSEKEEPING	0	1,470	33,975	0	9.00	
9.01	00901	HOUSEKEEPING-SCC	0	0	24,895	0	9.01	
10.00	01000	DIETARY	0	62,995	55,552	0	10.00	
10.01	01001	DIETARY-SCC	437	0	67,854	0	10.01	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01	
13.00	01300	NURSING ADMINISTRATION	0	179	66,646	0	13.00	
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	22,132	0	14.00	
15.00	01500	PHARMACY	0	6,308	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	696	46,340	0	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,286	105,145	222,118	41,113	81,603	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	7,137	0	404,977	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	173,216	52,391	32,970	58,936	50.00
53.00	05300	ANESTHESIOLOGY	0	13,391	0	7,261	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,815	172,747	93,422	95,142	58,936	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	150	8,788	86,391	65,088	22,668	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	7,337	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	587	0	2,441	0	65.00
66.00	06600	PHYSICAL THERAPY	513	15,820	289,710	50,708	113,338	66.00
66.01	06601	CARDIAC REHAB	0	0	7,793	2,681	4,534	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,166	4,819	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,727	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,742	0	73.00
76.00	03020	SLEEP LAB	0	12,703	4,917	938	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	115	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	168	15,193	120,850	0	145,069	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	6,152	0	49,869	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	11,336	0	0	9,067	90.00
91.00	09100	EMERGENCY	734	26,802	94,091	36,454	49,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY			
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO						
	2.00	2.01						
118.00	SUBTOTALS (SUM OF LINES 1-117)		22,818	876,241	2,085,089	380,524	702,695	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	322	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	11,882	0	75,070	0	0	194.01
194.02	07952	ADULT DAY CARE	239	315	31,018	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	32	1,009	3,930	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,971	877,887	2,195,107	380,524	702,695	202.00

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Health Financial Systems

MI DWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.03	5A.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING	225,099					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	1,834,532	1,834,532			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	907,248	96,646	0	1,003,894	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	313,858	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,948	5,108	0	8,277	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	61,984	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	199,183	21,218	0	6,278	9.00
9.01	00901	HOUSEKEEPING-SCC	0	123,928	0	0	0	9.01
10.00	01000	DIETARY	0	643,018	68,498	0	74,542	10.00
10.01	01001	DIETARY-SCC	0	424,221	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	332,813	35,453	0	2,976	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	148,110	15,778	0	15,857	14.00
15.00	01500	PHARMACY	0	155,918	16,609	0	17,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	283,337	30,183	0	15,973	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,421	2,128,405	226,730	0	205,768	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	13,962	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,050,860	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,179	1,092,299	116,358	0	125,182	50.00
53.00	05300	ANESTHESIOLOGY	3,783	248,993	26,524	0	1,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,568	1,536,682	163,697	0	84,423	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	33,913	951,430	101,352	0	25,018	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	3,823	32,105	3,420	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,272	17,029	1,814	0	4,371	65.00
66.00	06600	PHYSICAL THERAPY	26,421	1,884,679	200,767	0	108,697	66.00
66.01	06601	CARDIAC REHAB	1,397	82,492	8,788	0	4,069	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,511	156,180	16,637	0	8,649	67.00
68.00	06800	SPEECH PATHOLOGY	575	26,832	2,858	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,505	72,251	7,697	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,412	290,141	30,908	0	0	73.00
76.00	03020	SLEEP LAB	489	55,790	5,943	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	487	52	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	20,824	2,302,499	245,276	0	137,365	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,921	480,701	51,207	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	91	68,516	7,299	0	13,950	90.00
91.00	09100	EMERGENCY	18,994	2,397,488	255,389	0	128,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	225,099	21,365,919	1,762,209	0	989,456	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT		
		5.03	5A.03	5.04	6.00	7.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,200	2,471	0	6,905	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,444	1,113	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	424,615	45,233	0	0	194.01
194.02	07952	ADULT DAY CARE	0	158,258	16,859	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	18,065	1,924	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	44,337	4,723	0	7,533	194.05
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	225,099	22,044,838	1,834,532	0	1,003,894	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
		7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMINISTRATIVE					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-SCC	313,858				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,333			8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	990	0	62,974		8.01
9.00	00900	HOUSEKEEPING	0	0	0	226,679	9.00
9.01	00901	HOUSEKEEPING-SCC	1,882	0	0	0	125,810
10.00	01000	DIETARY	0	0	0	18,711	10.00
10.01	01001	DIETARY-SCC	7,315	0	0	0	4,299
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	3,280	0	0	747	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	3,980	14.00
15.00	01500	PHARMACY	0	0	0	4,511	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,009	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	61,333	0	51,652	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	8,585	0	0	0	5,045
46.00	04600	OTHER LONG TERM CARE	89,308	0	62,974	0	52,482
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	31,422	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,191	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	6,280	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,097	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,945	66.00
66.01	06601	CARDIAC REHAB	0	0	0	1,021	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	788	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	34,480	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	3,502	90.00
91.00	09100	EMERGENCY	0	0	0	32,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,360	61,333	62,974	225,990	63,753

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
		7.01	8.00	8.01	9.00	9.01	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	97,693	0	0	57,411	194.01
194.02	07952	ADULT DAY CARE	7,907	0	0	4,646	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	96,898	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	689	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	313,858	61,333	62,974	226,679	125,810

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIVE	
		10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00570						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00540						5.04
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000	804,769					10.00
10.01	01001	0	435,835				10.01
11.00	01100	0	0	0			11.00
11.01	01101	0	0	0	0		11.01
13.00	01300	0	0	0	0	377,196	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	804,769	0	0	0	301,688	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	0	0	44.00
46.00	04600	0	286,918	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	37,754	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	37,754	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		804,769	286,918	0	0	377,196	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION		
		10.00	10.01	11.00	11.01	13.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	29,877	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	119,040	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	804,769	435,835	0	0	377,196	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	183,725					14.00
15.00	01500	PHARMACY	0	195,011				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	719	0	334,221			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,426	0	31,805	0	3,832,576	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	27,592	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	2,542,542	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,127	0	25,505	0	1,465,647	50.00
53.00	05300	ANESTHESIOLOGY	2,928	0	5,617	0	285,633	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,138	0	73,608	0	1,894,739	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	50,351	0	1,134,431	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	7,118	0	5,676	0	48,319	64.00
65.00	06500	RESPIRATORY THERAPY	4,421	0	1,888	0	30,620	65.00
66.00	06600	PHYSICAL THERAPY	22,304	0	39,227	0	2,265,619	66.00
66.01	06601	CARDIAC REHAB	9,288	0	2,074	0	107,732	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,842	0	3,728	0	192,824	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	853	0	30,545	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	288	0	5,204	0	85,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89	195,011	19,914	0	536,063	73.00
76.00	03020	SLEEP LAB	2,450	0	726	0	64,909	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	539	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	21,990	0	30,917	0	2,772,527	88.00
88.01	08801	RURAL HEALTH CLINIC II	15,076	0	8,791	0	555,775	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	136	0	93,403	90.00
91.00	09100	EMERGENCY	17,519	0	28,201	0	2,897,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	183,725	195,011	334,221	0	20,864,997	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	32,576 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11,557 192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0 192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0 194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	654,829 194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	306,710 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	0	0	0	116,887 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	57,282 194.05
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	183,725	195,011	334,221	0	22,044,838 202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00550	INFORMATION TECHNOLOGY		5.02
5.03	00590	HOSPITAL BILLING		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-SCC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC		8.01
9.00	00900	HOUSEKEEPING		9.00
9.01	00901	HOUSEKEEPING-SCC		9.01
10.00	01000	DIETARY		10.00
10.01	01001	DIETARY-SCC		10.01
11.00	01100	CAFETERIA		11.00
11.01	01101	CAFETERIA-SCC		11.01
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	06601	CARDIAC REHAB	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	SLEEP LAB	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	FAMILY PRACTICE	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20,864,997	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,576	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	11,557	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	654,829	194.01
194.02	07952 ADULT DAY CARE	0	306,710	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954 IDLE SPACE	0	116,887	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	57,282	194.05
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	22,044,838	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS		0					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570 ADMITTING	0	0	0	58,311	0	5.01
5.02	00550 INFORMATION TECHNOLOGY	0	550	0	28,963	0	5.02
5.03	00590 HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL	0	7,199	24,974	349,942	0	5.04
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	0	0	271,373	0	7.00
7.01	00701 OPERATION OF PLANT-SCC	0	1,845	0	0	0	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	27,422	0	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	185	0	0	0	8.01
9.00	00900 HOUSEKEEPING	0	0	0	20,798	0	9.00
9.01	00901 HOUSEKEEPING-SCC	0	351	0	0	0	9.01
10.00	01000 DIETARY	0	0	0	246,955	0	10.00
10.01	01001 DIETARY-SCC	0	1,364	0	0	0	10.01
11.00	01100 CAFETERIA	0	0	0	0	0	11.00
11.01	01101 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300 NURSING ADMINISTRATION	0	612	0	9,860	0	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0	0	52,534	0	14.00
15.00	01500 PHARMACY	0	0	0	59,543	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	52,919	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	0	0	681,705	0	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	1,601	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	16,651	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	414,724	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	4,160	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,778	0	0	279,692	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	82,883	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	14,481	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	360,110	0	66.00
66.01	06601 CARDIAC REHAB	0	0	0	13,480	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	28,655	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,740	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	455,087	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	46,217	0	90.00
91.00	09100 EMERGENCY	0	0	0	426,817	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
				1.00	1.01	1.02	1.03	
113.00	11300	INTEREST EXPENSE	0					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,518	30,358	24,974	3,986,631	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22,878	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	53,741	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	4,349	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	18,065	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	24,957	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	18,518	48,423	83,064	4,034,466	0	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
		2.00	2.01				
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	58,311	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	42,707	72,220	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	555	165,109	547,779	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	39,318	310,691	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	3,023	0	4,868	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,731	29,153	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	185	0	8.01
9.00	00900	HOUSEKEEPING	0	1,470	22,268	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	351	0	9.01
10.00	01000	DIETARY	0	62,995	309,950	0	10.00
10.01	01001	DIETARY-SCC	437	0	1,801	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	179	10,651	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	52,534	0	14.00
15.00	01500	PHARMACY	0	6,308	65,851	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	696	53,615	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,286	105,145	791,136	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,601	0	44.00
46.00	04600	OTHER LONG TERM CARE	7,137	0	23,788	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	173,216	587,940	0	50.00
53.00	05300	ANESTHESIOLOGY	0	13,391	17,551	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,815	172,747	468,032	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	150	8,788	91,821	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,124	64.00
65.00	06500	RESPIRATORY THERAPY	0	587	15,068	0	65.00
66.00	06600	PHYSICAL THERAPY	513	15,820	376,443	0	66.00
66.01	06601	CARDIAC REHAB	0	0	13,480	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	28,655	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	169	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,740	0	73.00
76.00	03020	SLEEP LAB	0	12,703	12,703	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	168	15,193	470,448	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	11,336	57,553	0	90.00
91.00	09100	EMERGENCY	734	26,802	454,353	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING				
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO							
	2.00	2.01							
118.00	SUBTOTALS (SUM OF LINES 1-117)		22,818	876,241	4,959,540	4.00	58,311	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	322	23,200	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00	
194.01	07951	ASSISTED LIVING UNITS	11,882	0	65,623	0	0	194.01	
194.02	07952	ADULT DAY CARE	239	315	4,903	0	0	194.02	
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03	
194.04	07954	IDLE SPACE	0	0	18,065	0	0	194.04	
194.05	07955	COMMUNITY FITNESS CENTER	32	1,009	25,998	0	0	194.05	
200.00		Cross Foot Adjustments			0			200.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00	
202.00		TOTAL (sum lines 118-201)	34,971	877,887	5,097,329	0	58,311	202.00	

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Health Financial Systems

MI DWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00550	INFORMATION TECHNOLOGY	72,220					5.02
5.03	00590	HOSPITAL BILLING	0	0				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	3,727	0	551,506			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	2,330	0	29,054	0	342,075	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,535	0	2,820	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	6,379	0	2,139	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00	01000	DIETARY	1,398	0	20,592	0	25,400	10.00
10.01	01001	DIETARY-SCC	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	466	0	10,658	0	1,014	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	4,743	0	5,403	14.00
15.00	01500	PHARMACY	932	0	4,993	0	6,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,330	0	9,074	0	5,443	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,387	0	68,160	0	70,117	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,057	0	34,980	0	42,655	50.00
53.00	05300	ANESTHESIOLOGY	0	0	7,974	0	428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,057	0	49,211	0	28,767	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,330	0	30,469	0	8,525	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	1,028	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	545	0	1,489	65.00
66.00	06600	PHYSICAL THERAPY	11,648	0	60,355	0	37,038	66.00
66.01	06601	CARDIAC REHAB	466	0	2,642	0	1,386	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,002	0	2,947	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	859	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,314	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,291	0	0	73.00
76.00	03020	SLEEP LAB	0	0	1,787	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	16	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	14,910	0	73,735	0	46,807	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,125	0	15,394	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	932	0	2,194	0	4,754	90.00
91.00	09100	EMERGENCY	5,125	0	76,780	0	43,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,220	0	529,764	0	337,155	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
	5.02	5.03	5.04	6.00	7.00	
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	743	0	2,353	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	334	0	0	192.00
192.01 19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951 ASSISTED LIVING UNITS	0	0	13,598	0	0	194.01
194.02 07952 ADULT DAY CARE	0	0	5,068	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	0	579	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	0	0	1,420	0	2,567	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	72,220	0	551,506	0	342,075	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	4,868					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,508				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	15	0	200			8.01
9.00	00900	HOUSEKEEPING	0	0	0	30,786		9.00
9.01	00901	HOUSEKEEPING-SCC	29	0	0	0	380	9.01
10.00	01000	DIETARY	0	0	0	2,541		10.00
10.01	01001	DIETARY-SCC	113	0	0	0	13	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	51	0	0	101		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	541		14.00
15.00	01500	PHARMACY	0	0	0	613		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	545		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	33,508	0	7,012	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	133	0	0	0	15	44.00
46.00	04600	OTHER LONG TERM CARE	1,385	0	200	0	159	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,268	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	43	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,878	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	853	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	149	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,351	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	139	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	107	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,683	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	476	0	90.00
91.00	09100	EMERGENCY	0	0	0	4,392	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,726	33,508	200	30,692	193	118.00

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
			7.01	8.00	8.01	9.00	9.01	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	1,516	0	0	0	173	194.01
194.02	07952	ADULT DAY CARE	123	0	0	0	14	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	1,503	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	94	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,868	33,508	200	30,786	380	202.00

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIVE	
		10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMINISTRATIVE					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-SCC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING-SCC					9.01
10.00	01000	DIETARY	359,881				10.00
10.01	01001	DIETARY-SCC	0	1,927			10.01
11.00	01100	CAFETERIA	0	0	0		11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	22,947	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	359,881	0	0	18,353	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,269	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,297	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	359,881	1,269	0	22,947	118.00

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	132	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	526	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	359,881	1,927	0	0	22,947	202.00

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	63,221					14.00
15.00	01500	PHARMACY	0	78,513				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247	0	71,254			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,029	0	6,780		1,376,663	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		1,749	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		26,801	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,776	0	5,437		701,462	50.00
53.00	05300	ANESTHESIOLOGY	1,007	0	1,197		29,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,209	0	15,697		590,432	54.00
57.00	05700	CT SCAN	0	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		0	59.00
60.00	06000	LABORATORY	0	0	10,734		154,706	60.00
60.01	06001	BLOOD LABORATORY	0	0	0		0	60.01
64.00	06400	INTRAVENOUS THERAPY	2,449	0	1,210		5,811	64.00
65.00	06500	RESPIRATORY THERAPY	1,521	0	403		19,549	65.00
66.00	06600	PHYSICAL THERAPY	7,675	0	8,362		510,642	66.00
66.01	06601	CARDIAC REHAB	3,196	0	442		22,162	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,355	0	795		40,599	67.00
68.00	06800	SPEECH PATHOLOGY	1	0	182		1,211	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99	0	1,109		4,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31	78,513	4,245		104,764	73.00
76.00	03020	SLEEP LAB	843	0	155		15,632	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		16	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,567	0	6,591		624,741	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,188	0	1,874		27,581	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	0	29		65,938	90.00
91.00	09100	EMERGENCY	6,028	0	6,012		604,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0		0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,221	78,513	71,254	0	4,928,797	118.00

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
	14.00	15.00	16.00	19.00	24.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	26,296
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	334
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0
194.01	07951	ASSISTED LIVING UNITS	0	0	0	81,042
194.02	07952	ADULT DAY CARE	0	0	0	10,634
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0
194.04	07954	IDLE SPACE	0	0	0	20,147
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	30,079
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	63,221	78,513	71,254	5,097,329

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00550	INFORMATION TECHNOLOGY		5.02
5.03	00590	HOSPITAL BILLING		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-SCC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC		8.01
9.00	00900	HOUSEKEEPING		9.00
9.01	00901	HOUSEKEEPING-SCC		9.01
10.00	01000	DIETARY		10.00
10.01	01001	DIETARY-SCC		10.01
11.00	01100	CAFETERIA		11.00
11.01	01101	CAFETERIA-SCC		11.01
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	06601	CARDIAC REHAB	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	SLEEP LAB	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	FAMILY PRACTICE	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
118.00	SUBTOTALS (SUM OF LINES 1-117)	25.00	26.00	
		0	4,928,797	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,296	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	334	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	81,042	194.01
194.02	07952 ADULT DAY CARE	0	10,634	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954 IDLE SPACE	0	20,147	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	30,079	194.05
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,097,329	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					33,387	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMINISTRATIVE	0	0	757	0	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	578	0	376	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	7,569	8,900	4,543	0	530	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	2,886	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	3,206	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	417	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	8,850	0	4,092	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	6,814	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	5,552	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,076	0	143	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,675	0	490	66.00
66.01	06601	CARDIAC REHAB	0	0	175	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,908	0	160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	600	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,918	8,900	51,755	0	21,785	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	11,343	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	228	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	31	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	48,423	83,064	4,034,466	0	34,971	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.951074	2.806027	77.028906	0.000000	1.047444	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

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Health Financial Systems

Midwest Medical Center

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)						
	2.01		4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT							1.00
1.01 00101 NEW CAP REL COSTS-ALU BLDG							1.01
1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL							1.02
1.03 00103 NEW CAP REL COSTS-2007 MOB							1.03
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP							2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	874,905						2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0		7,119,503				4.00
5.01 00570 ADMITTING	0		243,343	19,501,533			5.01
5.02 00550 INFORMATION TECHNOLOGY	42,562		271,953	0	155		5.02
5.03 00590 HOSPITAL BILLING	0		0	0	0	22,141,047	5.03
5.04 00540 OTHER ADMINISTRATIVE AND GENERAL	164,548		557,760	0	8	0	5.04
6.00 00600 MAINTENANCE & REPAIRS	0		0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	39,184		79,807	0	5	0	7.00
7.01 00701 OPERATION OF PLANT-SCC	0		75,079	0	0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	1,725		0	0	0	0	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0		0	0	0	0	8.01
9.00 00900 HOUSEKEEPING	1,465		110,192	0	0	0	9.00
9.01 00901 HOUSEKEEPING-SCC	0		80,743	0	0	0	9.01
10.00 01000 DIETARY	62,781		180,175	0	3	0	10.00
10.01 01001 DIETARY-SCC	0		220,075	0	0	0	10.01
11.00 01100 CAFETERIA	0		0	0	0	0	11.00
11.01 01101 CAFETERIA-SCC	0		0	0	0	0	11.01
13.00 01300 NURSING ADMINISTRATION	178		216,155	0	1	0	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0		71,782	0	0	0	14.00
15.00 01500 PHARMACY	6,287		0	0	2	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	694		150,297	0	5	0	16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	104,788		720,406	2,106,962	18	2,106,962	30.00
41.00 04100 SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0		0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	0		1,313,480	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	172,628		169,922	1,689,644	13	1,689,644	50.00
53.00 05300 ANESTHESIOLOGY	13,346		0	372,102	0	372,102	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	172,160		303,001	4,876,336	13	4,876,336	54.00
57.00 05700 CT SCAN	0		0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00 06000 LABORATORY	8,758		280,197	3,335,621	5	3,335,621	60.00
60.01 06001 BLOOD LABORATORY	0		0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0		0	375,993	0	375,993	64.00
65.00 06500 RESPIRATORY THERAPY	585		0	125,096	0	125,096	65.00
66.00 06600 PHYSICAL THERAPY	15,766		939,633	2,598,662	25	2,598,662	66.00
66.01 06601 CARDIAC REHAB	0		25,277	137,411	1	137,411	66.01
67.00 06700 OCCUPATIONAL THERAPY	0		19,997	246,982	0	246,982	67.00
68.00 06800 SPEECH PATHOLOGY	0		0	56,512	0	56,512	68.00
69.00 06900 ELECTROCARDIOLOGY	0		0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	344,722	0	344,722	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	1,319,214	0	1,319,214	73.00
76.00 03020 SLEEP LAB	12,660		15,948	48,073	0	48,073	76.00
76.01 03950 PAIN CLINIC / SERVICE	0		0	0	0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0		372	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	15,141		391,960	0	32	2,048,158	88.00
88.01 08801 RURAL HEALTH CLINIC II	0		19,954	0	11	582,368	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00 09000 CLINIC	11,297		0	0	2	8,988	90.00
91.00 09100 EMERGENCY	26,711		305,169	1,868,203	11	1,868,203	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0		0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0		0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0		0	0	0	0	110.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTING (GROSS CHARGES)	I NFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BI LLI NG (GROSS CHARGES HOSP BI LLI NG)	
		NEW MVBLE EQUI P NEW HO (DOLLAR VALUE)					
		2. 01	4. 00	5. 01	5. 02	5. 03	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	873,264	6,762,677	19,501,533	155	22,141,047
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	243,479	0	0	194.01
194.02	07952	ADULT DAY CARE	314	100,601	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	1,006	12,746	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	877,887	2,195,107	380,524	702,695	225,099
203.00		Unit cost multiplier (Wkst. B, Part I)	1.003408	0.308323	0.019513	4,533.516129	0.010167
204.00		Cost to be allocated (per Wkst. B, Part II)		0	58,311	72,220	0
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000	0.002990	465.935484	0.000000

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)		
		5A.04	5.04	6.00	7.00	7.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02	
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00570	ADMINITTING					5.01	
5.02	00550	INFORMATION TECHNOLOGY					5.02	
5.03	00590	HOSPITAL BILLING					5.03	
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-1,834,532	17,221,493			5.04	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00	
7.00	00700	OPERATION OF PLANT	0	907,248	0	43,177	7.00	
7.01	00701	OPERATION OF PLANT-SCC	-313,858	0	0	61,529	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,948	0	356	8.00	
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	-61,984	0	0	194	8.01	
9.00	00900	HOUSEKEEPING	0	199,183	0	270	9.00	
9.01	00901	HOUSEKEEPING-SCC	-123,928	0	0	369	9.01	
10.00	01000	DIETARY	0	643,018	0	3,206	10.00	
10.01	01001	DIETARY-SCC	-424,221	0	0	1,434	10.01	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01	
13.00	01300	NURSING ADMINISTRATION	0	332,813	0	128	13.00	
14.00	01400	CENTRAL SERVICE & SUPPLY	0	148,110	0	682	14.00	
15.00	01500	PHARMACY	0	155,918	0	773	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	283,337	0	687	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,128,405	0	8,850	30.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
44.00	04400	SKILLED NURSING FACILITY	-13,962	0	0	1,683	44.00	
46.00	04600	OTHER LONG TERM CARE	-2,050,860	0	0	17,508	46.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,092,299	0	5,384	50.00	
53.00	05300	ANESTHESIOLOGY	0	248,993	0	54	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,536,682	0	3,631	54.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	951,430	0	1,076	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
64.00	06400	INTRAVENOUS THERAPY	0	32,105	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	17,029	0	188	65.00	
66.00	06600	PHYSICAL THERAPY	0	1,884,679	0	4,675	66.00	
66.01	06601	CARDIAC REHAB	0	82,492	0	175	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0	156,180	0	372	67.00	
68.00	06800	SPEECH PATHOLOGY	0	26,832	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72,251	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	290,141	0	0	73.00	
76.00	03020	SLEEP LAB	0	55,790	0	0	76.00	
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01	
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	487	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,302,499	0	5,908	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	480,701	0	0	88.01	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	68,516	0	600	90.00	
91.00	09100	EMERGENCY	0	2,397,488	0	5,541	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,823,345	16,542,574	0	42,556	21,831	118.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)		
		5A.04	5.04	6.00	7.00	7.01		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,200	0	297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,444	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	424,615	0	0	19,152	194.01
194.02	07952	ADULT DAY CARE	0	158,258	0	0	1,550	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	18,065	0	0	18,996	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	44,337	0	324	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,834,532	0	1,003,894	313,858	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.106526	0.000000	23.250666	5.100977	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		551,506	0	342,075	4,868	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.032024	0.000000	7.922621	0.079117	205.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
		8.00	8.01	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-SCC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,086				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	18,371			8.01
9.00	00900	HOUSEKEEPING	0	0	38,840		9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	41,970	9.01
10.00	01000	DIETARY	0	0	3,206	2,086	10.00
10.01	01001	DIETARY-SCC	0	0	0	1,434	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	128	643	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	14.00
15.00	01500	PHARMACY	0	0	773	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,086	0	8,850	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,683	44.00
46.00	04600	OTHER LONG TERM CARE	0	18,371	0	17,508	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	5,384	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,076	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,704	0	66.00
66.01	06601	CARDIAC REHAB	0	0	175	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	135	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	5,908	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	600	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING- SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
		8.00	8.01	9.00	9.01	10.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,086	18,371	38,722	21,268	2,086	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	0	0	19,152	0	194.01
194.02	07952 ADULT DAY CARE	0	0	0	1,550	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	118	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	61,333	62,974	226,679	125,810	804,769	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.402205	3.427903	5.836226	2.997617	385.795302	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	33,508	200	30,786	380	359,881	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	16.063279	0.010887	0.792636	0.009054	172.522052	205.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		10.01	11.00	11.01	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00570						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00540						5.04
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001	27,906					10.01
11.00	01100	0	0				11.00
11.01	01101	0	0	0			11.01
13.00	01300	0	0	0	2,168		13.00
14.00	01400	0	0	0	0	540,618	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	2,115	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	1,734	60,104	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	0	0	44.00
46.00	04600	18,371	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	217	109,251	50.00
53.00	05300	0	0	0	0	8,615	53.00
54.00	05400	0	0	0	0	44,543	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	20,945	64.00
65.00	06500	0	0	0	0	13,010	65.00
66.00	06600	0	0	0	0	65,629	66.00
66.01	06601	0	0	0	0	27,330	66.01
67.00	06700	0	0	0	0	20,134	67.00
68.00	06800	0	0	0	0	7	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	848	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	261	73.00
76.00	03020	0	0	0	0	7,210	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	64,705	88.00
88.01	08801	0	0	0	0	44,362	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	217	51,549	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		10.01	11.00	11.01	13.00	14.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,371	0	0	2,168	540,618	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	1,913	0	0	0	0	194.01
194.02	07952 ADULT DAY CARE	7,622	0	0	0	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	435,835	0	0	377,196	183,725	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.617967	0.000000	0.000000	173.983395	0.339843	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,927	0	0	22,947	63,221	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.069053	0.000000	0.000000	10.584410	0.116942	205.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570 ADMITTING				5.01
5.02	00550 INFORMATION TECHNOLOGY				5.02
5.03	00590 HOSPITAL BILLING				5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600 MAINTENANCE & REPAIRS				6.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 OPERATION OF PLANT-SCC				7.01
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900 HOUSEKEEPING				9.00
9.01	00901 HOUSEKEEPING-SCC				9.01
10.00	01000 DIETARY				10.00
10.01	01001 DIETARY-SCC				10.01
11.00	01100 CAFETERIA				11.00
11.01	01101 CAFETERIA-SCC				11.01
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY				14.00
15.00	01500 PHARMACY	1,319,214			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	22,141,047		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	2,106,962	0	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	1,689,644	0	50.00
53.00	05300 ANESTHESIOLOGY	0	372,102	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,876,336	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	3,335,621	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	375,993	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	125,096	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,598,662	0	66.00
66.01	06601 CARDIAC REHAB	0	137,411	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	246,982	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	56,512	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	344,722	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,319,214	1,319,214	0	73.00
76.00	03020 SLEEP LAB	0	48,073	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	2,048,158	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	582,368	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	8,988	0	90.00
91.00	09100 EMERGENCY	0	1,868,203	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	111.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1

Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		15.00	16.00	19.00	
113.00	11300 INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,319,214	22,141,047	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	0	0	194.01
194.02	07952 ADULT DAY CARE	0	0	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	194.05
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	195,011	334,221	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.147824	0.015095	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,513	71,254	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.059515	0.003218	0.000000	205.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,832,576		3,832,576	0	3,832,576	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	27,592		27,592	0	27,592	44.00
46.00	04600	OTHER LONG TERM CARE	2,542,542		2,542,542	0	2,542,542	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,465,647		1,465,647	0	1,465,647	50.00
53.00	05300	ANESTHESIOLOGY	285,633		285,633	0	285,633	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,894,739		1,894,739	0	1,894,739	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,134,431		1,134,431	0	1,134,431	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	48,319		48,319	0	48,319	64.00
65.00	06500	RESPIRATORY THERAPY	30,620	0	30,620	0	30,620	65.00
66.00	06600	PHYSICAL THERAPY	2,265,619	0	2,265,619	0	2,265,619	66.00
66.01	06601	CARDIAC REHAB	107,732	0	107,732	0	107,732	66.01
67.00	06700	OCCUPATIONAL THERAPY	192,824	0	192,824	0	192,824	67.00
68.00	06800	SPEECH PATHOLOGY	30,545	0	30,545	0	30,545	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,440		85,440	0	85,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,063		536,063	0	536,063	73.00
76.00	03020	SLEEP LAB	64,909		64,909	0	64,909	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	539		539	0	539	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,772,527		2,772,527	0	2,772,527	88.00
88.01	08801	RURAL HEALTH CLINIC II	555,775		555,775	0	555,775	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	93,403		93,403	0	93,403	90.00
91.00	09100	EMERGENCY	2,897,522		2,897,522	0	2,897,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,024		174,024	0	174,024	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,039,021	0	21,039,021	0	21,039,021	200.00
201.00		Less Observation Beds	174,024		174,024		174,024	201.00
202.00		Total (see instructions)	20,864,997	0	20,864,997	0	20,864,997	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet C Part I Date/Time Prepared: 2/12/2018 1:26 pm		
			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,992,561		1,992,561				30.00
41.00	04100	SUBPROVIDER - IRF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
46.00	04600	OTHER LONG TERM CARE	4,239,538		4,239,538				46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	1,689,644	1,689,644	0.867429	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0	372,102	372,102	0.767620	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,914	4,764,423	4,876,337	0.388558	0.000000		54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	194,251	3,141,370	3,335,621	0.340096	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	48,773	327,220	375,993	0.128510	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	104,962	20,134	125,096	0.244772	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	500,692	2,097,970	2,598,662	0.871841	0.000000		66.00
66.01	06601	CARDIAC REHAB	0	137,411	137,411	0.784013	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	176,022	70,959	246,981	0.780724	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	12,482	44,030	56,512	0.540505	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,844	304,878	344,722	0.247852	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	629,043	690,171	1,319,214	0.406350	0.000000		73.00
76.00	03020	SLEEP LAB	0	48,073	48,073	1.350217	0.000000		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	0.000000		76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	2,048,158	2,048,158				88.00
88.01	08801	RURAL HEALTH CLINIC II	0	582,368	582,368				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				89.00
90.00	09000	CLINIC	0	8,988	8,988	10.391967	0.000000		90.00
91.00	09100	EMERGENCY	10,925	1,857,278	1,868,203	1.550967	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	114,401	114,401	1.521176	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0				99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
200.00		Subtotal (see instructions)	8,061,007	18,319,578	26,380,585				200.00
201.00		Less Observation Beds	0	0	0				201.00
202.00		Total (see instructions)	8,061,007	18,319,578	26,380,585				202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
44.00	04400 SKILLED NURSING FACILITY				44.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
66.01	06601 CARDIAC REHAB	0.000000			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 SLEEP LAB	0.000000			76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000			76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,832,576		3,832,576	0	3,832,576
41.00	04100 SUBPROVIDER - IRF	0		0	0	0
42.00	04200 SUBPROVIDER	0		0	0	0
44.00	04400 SKILLED NURSING FACILITY	27,592		27,592	0	27,592
46.00	04600 OTHER LONG TERM CARE	2,542,542		2,542,542	0	2,542,542
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,465,647		1,465,647	0	1,465,647
53.00	05300 ANESTHESIOLOGY	285,633		285,633	0	285,633
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,894,739		1,894,739	0	1,894,739
57.00	05700 CT SCAN	0		0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000 LABORATORY	1,134,431		1,134,431	0	1,134,431
60.01	06001 BLOOD LABORATORY	0		0	0	0
64.00	06400 INTRAVENOUS THERAPY	48,319		48,319	0	48,319
65.00	06500 RESPIRATORY THERAPY	30,620	0	30,620	0	30,620
66.00	06600 PHYSICAL THERAPY	2,265,619	0	2,265,619	0	2,265,619
66.01	06601 CARDIAC REHAB	107,732	0	107,732	0	107,732
67.00	06700 OCCUPATIONAL THERAPY	192,824	0	192,824	0	192,824
68.00	06800 SPEECH PATHOLOGY	30,545	0	30,545	0	30,545
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	85,440		85,440	0	85,440
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	536,063		536,063	0	536,063
76.00	03020 SLEEP LAB	64,909		64,909	0	64,909
76.01	03950 PAIN CLINIC / SERVICE	0		0	0	0
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	539		539	0	539
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2,772,527		2,772,527	0	2,772,527
88.01	08801 RURAL HEALTH CLINIC II	555,775		555,775	0	555,775
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000 CLINIC	93,403		93,403	0	93,403
91.00	09100 EMERGENCY	2,897,522		2,897,522	0	2,897,522
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	174,024		174,024	0	174,024
93.00	04040 FAMILY PRACTICE	0		0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0		0
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0		0		0
110.00	11000 INTESTINAL ACQUISITION	0		0		0
111.00	11100 ISLET ACQUISITION	0		0		0
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	21,039,021	0	21,039,021	0	21,039,021
201.00	Less Observation Beds	174,024		174,024		174,024
202.00	Total (see instructions)	20,864,997	0	20,864,997	0	20,864,997

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,992,561		1,992,561		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	4,239,538		4,239,538		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,689,644	1,689,644	0.867429	50.00
53.00	05300	ANESTHESIOLOGY	0	372,102	372,102	0.767620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,914	4,764,423	4,876,337	0.388558	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	194,251	3,141,370	3,335,621	0.340096	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	48,773	327,220	375,993	0.128510	64.00
65.00	06500	RESPIRATORY THERAPY	104,962	20,134	125,096	0.244772	65.00
66.00	06600	PHYSICAL THERAPY	500,692	2,097,970	2,598,662	0.871841	66.00
66.01	06601	CARDIAC REHAB	0	137,411	137,411	0.784013	66.01
67.00	06700	OCCUPATIONAL THERAPY	176,022	70,959	246,981	0.780724	67.00
68.00	06800	SPEECH PATHOLOGY	12,482	44,030	56,512	0.540505	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,844	304,878	344,722	0.247852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	629,043	690,171	1,319,214	0.406350	73.00
76.00	03020	SLEEP LAB	0	48,073	48,073	1.350217	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,048,158	2,048,158	1.353669	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	582,368	582,368	0.954336	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	8,988	8,988	10.391967	90.00
91.00	09100	EMERGENCY	10,925	1,857,278	1,868,203	1.550967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	114,401	114,401	1.521176	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	8,061,007	18,319,578	26,380,585		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,061,007	18,319,578	26,380,585		202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Prepared: 2/12/2018 1:26 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
44.00	04400	SKILLED NURSING FACILITY		44.00
46.00	04600	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	CARDIAC REHAB	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	SLEEP LAB	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF		99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	701,462	1,689,644	0.415154	0	0	50.00
53.00	05300	ANESTHESIOLOGY	29,313	372,102	0.078777	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,432	4,876,337	0.121081	54,244	6,568	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	154,706	3,335,621	0.046380	89,638	4,157	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	5,811	375,993	0.015455	34,275	530	64.00
65.00	06500	RESPIRATORY THERAPY	19,549	125,096	0.156272	37,644	5,883	65.00
66.00	06600	PHYSICAL THERAPY	510,642	2,598,662	0.196502	34,035	6,688	66.00
66.01	06601	CARDIAC REHAB	22,162	137,411	0.161283	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	40,599	246,981	0.164381	7,952	1,307	67.00
68.00	06800	SPEECH PATHOLOGY	1,211	56,512	0.021429	501	11	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,553	344,722	0.013208	14,423	190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,764	1,319,214	0.079414	115,737	9,191	73.00
76.00	03020	SLEEP LAB	15,632	48,073	0.325172	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	16	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	624,741	2,048,158	0.305026	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	27,581	582,368	0.047360	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	65,938	8,988	7.336226	0	0	90.00
91.00	09100	EMERGENCY	604,472	1,868,203	0.323558	7,288	2,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,509	114,401	0.546403	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00		Total (Lines 50-199)	3,586,093	20,148,486		395,737	36,883	200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Title XVIII			Hospital		Total Cost (sum of col 1 through col . 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	5.00		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	Cost
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,689,644	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	372,102	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,876,337	0.000000	0.000000	54,244	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	3,335,621	0.000000	0.000000	89,638	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	375,993	0.000000	0.000000	34,275	64.00
65.00	06500	RESPIRATORY THERAPY	0	125,096	0.000000	0.000000	37,644	65.00
66.00	06600	PHYSICAL THERAPY	0	2,598,662	0.000000	0.000000	34,035	66.00
66.01	06601	CARDIAC REHAB	0	137,411	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	246,981	0.000000	0.000000	7,952	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,512	0.000000	0.000000	501	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	344,722	0.000000	0.000000	14,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,319,214	0.000000	0.000000	115,737	73.00
76.00	03020	SLEEP LAB	0	48,073	0.000000	0.000000	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0.000000	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,048,158	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	582,368	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	8,988	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,868,203	0.000000	0.000000	7,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	114,401	0.000000	0.000000	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00		Total (Lines 50-199)	0	20,148,486			395,737	200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 CARDIAC REHAB	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SLEEP LAB	0	0	0		76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0		76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0		93.00
200.00	Total (Lines 50-199)	0	0	0		200.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part V
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.867429	0	642,497	0	0
53.00	05300 ANESTHESIOLOGY	0.767620	0	130,768	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.388558	0	1,513,802	0	0
57.00	05700 CT SCAN	0.000000	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000 LABORATORY	0.340096	0	1,219,900	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.128510	0	93,013	0	0
65.00	06500 RESPIRATORY THERAPY	0.244772	0	8,717	0	0
66.00	06600 PHYSICAL THERAPY	0.871841	0	965,393	0	0
66.01	06601 CARDIAC REHAB	0.784013	0	89,687	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.780724	0	37,030	0	0
68.00	06800 SPEECH PATHOLOGY	0.540505	0	19,167	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.247852	0	133,643	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.406350	0	240,266	4,957	0
76.00	03020 SLEEP LAB	1.350217	0	24,845	0	0
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	0	0	0
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0
88.01	08801 RURAL HEALTH CLINIC II	0.000000				0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00	09000 CLINIC	10.391967	0	3,528	0	0
91.00	09100 EMERGENCY	1.550967	0	780,985	2,688	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.521176	0	63,635	0	0
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	0
200.00	Subtotal (see instructions)		0	5,966,876	7,645	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 +/- line 201)		0	5,966,876	7,645	0

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Prepared: 2/12/2018 1:26 pm
Title XVIII		Hospital	Cost

	Cost Center Description	Costs			
		Cost	Cost		
		Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	557,321	0		50.00
53.00	05300 ANESTHESIOLOGY	100,380	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	588,200	0		54.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	414,883	0		60.00
60.01	06001 BLOOD LABORATORY	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	11,953	0		64.00
65.00	06500 RESPIRATORY THERAPY	2,134	0		65.00
66.00	06600 PHYSICAL THERAPY	841,669	0		66.00
66.01	06601 CARDIAC REHAB	70,316	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	28,910	0		67.00
68.00	06800 SPEECH PATHOLOGY	10,360	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33,124	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97,632	2,014		73.00
76.00	03020 SLEEP LAB	33,546	0		76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	36,663	0		90.00
91.00	09100 EMERGENCY	1,211,282	4,169		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	96,800	0		92.00
93.00	04040 FAMILY PRACTICE	0	0		93.00
200.00	Subtotal (see instructions)	4,135,173	6,183		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	4,135,173	6,183		202.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period: From 10/01/2016

Worksheet D

Component CCN: 14-Z302

To 09/30/2017

Part V
Date/Time Prepared:
2/12/2018 1:26 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.867429	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.767620	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.388558	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.340096	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.128510	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.244772	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.871841	0	0	0	0
66.01 06601 CARDIAC REHAB	0.784013	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.780724	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.540505	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.247852	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.406350	0	0	0	0
76.00 03020 SLEEP LAB	1.350217	0	0	0	0
76.01 03950 PAIN CLINIC / SERVICE	0.000000	0	0	0	0
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
88.01 08801 RURAL HEALTH CLINIC II	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	10.391967	0	0	0	0
91.00 09100 EMERGENCY	1.550967	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.521176	0	0	0	0
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:

Worksheet D

Component CCN: 14-Z302

From 10/01/2016
To 09/30/2017

Part V
Date/Time Prepared:
2/12/2018 1:26 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 CARDIAC REHAB	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 SLEEP LAB	0	0		76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0		76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 FAMILY PRACTICE	0	0		93.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/12/2018 1:26 pm
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/12/2018 1:26 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	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
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	1,689,644	0.000000	0.000000	0 50.00
53.00 05300 ANESTHESIOLOGY	0	372,102	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	4,876,337	0.000000	0.000000	0 54.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	3,335,621	0.000000	0.000000	0 60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
64.00 06400 INTRAVENOUS THERAPY	0	375,993	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	125,096	0.000000	0.000000	0 65.00
66.00 06600 PHYSICAL THERAPY	0	2,598,662	0.000000	0.000000	0 66.00
66.01 06601 CARDIAC REHAB	0	137,411	0.000000	0.000000	0 66.01
67.00 06700 OCCUPATIONAL THERAPY	0	246,981	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	56,512	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	344,722	0.000000	0.000000	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,319,214	0.000000	0.000000	0 73.00
76.00 03020 SLEEP LAB	0	48,073	0.000000	0.000000	0 76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0	0.000000	0.000000	0 76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0.000000	0.000000	0 76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	2,048,158	0.000000	0.000000	0 88.00
88.01 08801 RURAL HEALTH CLINIC II	0	582,368	0.000000	0.000000	0 88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0 89.00
90.00 09000 CLINIC	0	8,988	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	1,868,203	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	114,401	0.000000	0.000000	0 92.00
93.00 04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0 93.00
200.00 Total (lines 50-199)	0	20,148,486			0 200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/12/2018 1:26 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 05700 CT SCAN	0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 06000 LABORATORY	0	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0		66.00
66.01 06601 CARDIAC REHAB	0	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 03020 SLEEP LAB	0	0	0		76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0	0		76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 09000 CLINIC	0	0	0		90.00
91.00 09100 EMERGENCY	0	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 04040 FAMILY PRACTICE	0	0	0		93.00
200.00 Total (lines 50-199)	0	0	0		200.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,086	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		441	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		351	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		499	5.00
6.00	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)		1,034	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		4	7.00
8.00	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)		108	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		287	9.00
10.00	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)		499	10.00
11.00	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)		769	11.00
12.00	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		0	12.00
13.00	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)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,832,576	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		560	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		15,120	25.00
26.00	Total swing-bed cost (see instructions)		2,979,858	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		852,718	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		852,718	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,933.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		554,937	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		554,937	41.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm	
Title XVIII			Hospital	Cost		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				163,242	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				718,179	49.00
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				964,856	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				1,486,923	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				2,451,779	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				90	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,933.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				174,024	89.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302		Period: From 10/01/2016 To 09/30/2017		Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,376,663	3,832,576	0.359200	174,024	62,509	90.00
91.00	Nursing School cost	0	3,832,576	0.000000	174,024	0	91.00
92.00	Allied health cost	0	3,832,576	0.000000	174,024	0	92.00
93.00	All other Medical Education	0	3,832,576	0.000000	174,024	0	93.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			0 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	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)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	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)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0 9.00
10.00	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)			0 10.00
11.00	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)			0 11.00
12.00	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			0 12.00
13.00	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)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,592	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27,592	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,592	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					54.00
55.00	Target amount per discharge					55.00
56.00	Target amount (line 54 x line 55)					56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00	Bonus payment (see instructions)					58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00	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 (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00	Relief payment (see instructions)					62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					27,592 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00 71.00
72.00	Program routine service cost (line 9 x line 71)					0 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)					0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0 80.00
81.00	Inpatient routine service cost per diem limitation					0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0 83.00
84.00	Program inpatient ancillary services (see instructions)					0 84.00
85.00	Utilization review - physician compensation (see instructions)					0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/12/2018 1:26 pm	
		Title XVIII		Ski lled Nursi ng Fac i lity	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0 90.00
91.00	Nursing School cost	0	0	0.000000	0	0 91.00
92.00	Allied health cost	0	0	0.000000	0	0 92.00
93.00	All other Medical Education	0	0	0.000000	0	0 93.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/12/2018 1:26 pm
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Title XVIII		Hospital	Cost	
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS		346,639		30.00
41.00 04100 SUBPROVIDER - IRF		0		41.00
42.00 04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.867429	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.767620	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.388558	54,244	21,077	54.00
57.00 05700 CT SCAN	0.000000	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00 06000 LABORATORY	0.340096	89,638	30,486	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0.128510	34,275	4,405	64.00
65.00 06500 RESPIRATORY THERAPY	0.244772	37,644	9,214	65.00
66.00 06600 PHYSICAL THERAPY	0.871841	34,035	29,673	66.00
66.01 06601 CARDIAC REHAB	0.784013	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.780724	7,952	6,208	67.00
68.00 06800 SPEECH PATHOLOGY	0.540505	501	271	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.247852	14,423	3,575	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.406350	115,737	47,030	73.00
76.00 03020 SLEEP LAB	1.350217	0	0	76.00
76.01 03950 PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00 09000 CLINIC	10.391967	0	0	90.00
91.00 09100 EMERGENCY	1.550967	7,288	11,303	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.521176	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		395,737	163,242
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		395,737	202.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-Z302	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/12/2018 1:26 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.867429	0	50.00
53.00	05300	ANESTHESIOLOGY	0.767620	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.388558	33,894	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.340096	103,529	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.128510	13,800	64.00
65.00	06500	RESPIRATORY THERAPY	0.244772	45,841	65.00
66.00	06600	PHYSICAL THERAPY	0.871841	360,239	66.00
66.01	06601	CARDIAC REHAB	0.784013	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.780724	130,367	67.00
68.00	06800	SPEECH PATHOLOGY	0.540505	11,050	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.247852	20,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.406350	316,112	73.00
76.00	03020	SLEEP LAB	1.350217	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	10.391967	0	90.00
91.00	09100	EMERGENCY	1.550967	2,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.521176	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,037,976	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,037,976	202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.867429	0	0 50.00
53.00	05300 ANESTHESIOLOGY	0.767620	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.388558	0	0 54.00
57.00	05700 CT SCAN	0.000000	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.340096	0	0 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
64.00	06400 INTRAVENOUS THERAPY	0.128510	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.244772	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.871841	0	0 66.00
66.01	06601 CARDIAC REHAB	0.784013	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	0.780724	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.540505	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.247852	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.406350	0	0 73.00
76.00	03020 SLEEP LAB	1.350217	0	0 76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	0 76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0 76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0 88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0 88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000 CLINIC	10.391967	0	0 90.00
91.00	09100 EMERGENCY	1.550967	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.521176	0	0 92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0 93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		0	0 202.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,141,356	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,141,356	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	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)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,182,770	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		22,595	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		936,032	26.00
27.00	Subtotal [(Lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,224,143	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,224,143	30.00
31.00	Primary payer payments		3,998	31.00
32.00	Subtotal (line 30 minus line 31)		3,220,145	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		41,193	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		26,775	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,094	36.00
37.00	Subtotal (see instructions)		3,246,920	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,246,920	40.00
40.01	Sequestration adjustment (see instructions)		64,938	40.01
41.00	Interim payments		2,841,012	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		340,970	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	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)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		639,148		2,947,385	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	03/30/2017	18,722		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	03/30/2017	106,373	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		18,722		-106,373	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		657,870		2,841,012	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		340,970	6.01
6.02	SETTLEMENT TO PROGRAM		46,986		0	6.02
7.00	Total Medicare program liability (see instructions)		610,884		3,181,982	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period: From 10/01/2016

Worksheet E-1

Component CCN: 14-Z302

To 09/30/2017

Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,972,414		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	03/30/2017	173,749		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		173,749		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,146,163		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		141,449		0	6.02
7.00	Total Medicare program liability (see instructions)		3,004,714		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302
Component CCN: 14-6140

Period:
From 10/01/2016
To 09/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
2/12/2018 1:26 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1302	Period:	Worksheet E-2	
		Component CCN: 14-Z302	From 10/01/2016 To 09/30/2017	Date/Time Prepared: 2/12/2018 1:26 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,476,297	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			0	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		626,922	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,268	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,103,219	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,103,219	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,103,219	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		37,184	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		3,066,035	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0	0	16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		3,066,035	0	19.00
19.01	Sequestration adjustment (see instructions)		61,321	0	19.01
20.00	Interim payments		3,146,163	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-141,449	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		718,179	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		718,179	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		725,361	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		725,361	19.00
20.00	Deductibles (exclude professional component)		102,256	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		623,105	22.00
23.00	Coinurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		623,105	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		379	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		246	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		623,351	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		623,351	30.00
30.01	Sequestration adjustment (see instructions)		12,467	30.01
31.00	Interim payments		657,870	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)		-46,986	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		0	18.00
19.00	Protected amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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In Lieu of Form CMS-2552-10

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

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet G

Date/Time Prepared:
2/12/2018 1:26 pm

		General Fund	Speci fic Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,523,324	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,400,919	0	0	0	4.00
5.00	Other receivable	92,857	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,595,972	0	0	0	6.00
7.00	Inventory	398,902	0	0	0	7.00
8.00	Prepaid expenses	144,289	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,964,319	0	0	0	11.00
FIXED ASSETS						
12.00	Land	448,597	0	0	0	12.00
13.00	Land improvements	3,759,243	0	0	0	13.00
14.00	Accumulated depreciation	-2,247,280	0	0	0	14.00
15.00	Buildings	38,424,141	0	0	0	15.00
16.00	Accumulated depreciation	-17,681,898	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,281,992	0	0	0	23.00
24.00	Accumulated depreciation	-6,699,615	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	2,580,130	0	0	0	27.00
28.00	Accumulated depreciation	-1,271,063	0	0	0	28.00
29.00	Minor equipment-nondepreciable	199,961	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,794,208	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	8,204,681	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,527,068	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,731,749	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,490,276	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	783,719	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,039,434	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	600,139	0	0	0	40.00
41.00	Deferred income	967,265	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	100,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,490,557	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	43,248,565	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,248,565	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,739,122	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-5,248,846	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-5,248,846	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,490,276	0	0	0	60.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-1

Date/Time Prepared:
2/12/2018 1:26 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-4,708,510		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-517,721				2.00
3.00	Total (sum of line 1 and line 2)		-5,226,231		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-5,226,231		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	LOANS FORGIVEN	22,616		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		22,616		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,248,847		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0		0		4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	LOANS FORGIVEN		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/12/2018 1:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,992,561		1,992,561	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	4,239,538		4,239,538	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,232,099		6,232,099	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,232,099		6,232,099	17.00
18.00	Ancillary services	1,828,908		1,828,908	18.00
19.00	Outpatient services	0	15,722,460	15,722,460	19.00
20.00	RURAL HEALTH CLINIC	0	2,048,158	2,048,158	20.00
20.01	RURAL HEALTH CLINIC II	0	582,368	582,368	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	2,969,079	2,969,079	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,061,007	21,322,065	29,383,072	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,801,336		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	1,074,965			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,074,965		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,876,301		43.00

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Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-3

Date/Time Prepared:
2/12/2018 1:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,383,072	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,082,792	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,300,280	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,876,301	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,576,021	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	88,022	6.00
7.00	Income from investments	31,671	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	255,176	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	137,053	17.00
18.00	Revenue from sale of medical records and abstracts	5,103	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	16,992	22.00
23.00	Governmental appropriations	332	23.00
24.00	AQUATICS REVENUE	25,994	24.00
24.01	ASSISTED LIVING UNITS	674,155	24.01
24.02	ADULT DAY CARE PROGRAM	194,153	24.02
24.03	FITNESS CENTER REVENUE	157,427	24.03
24.04	GRANT REVENUE	380,303	24.04
24.05	MISCELLANEOUS REVENUE	66,419	24.05
24.06	GAIN ON SALE OF EQUIP AND FORG OF DE	25,500	24.06
25.00	Total other income (sum of lines 6-24)	2,058,300	25.00
26.00	Total (line 5 plus line 25)	-517,721	26.00
27.00		0	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-517,721	29.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period: From 10/01/2016

Worksheet M-1

Component CCN: 14-8511

To 09/30/2017

Date/Time Prepared: 2/12/2018 1:26 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	871,661	0	871,661	-28,004	843,657	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	155,125	0	155,125	-9,440	145,685	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	254,338	0	254,338	0	254,338	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	181	34,525	34,706	-29,220	5,486	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,281,305	34,525	1,315,830	-66,664	1,249,166	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	12,437	12,437	0	12,437	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,437	12,437	0	12,437	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,281,305	46,962	1,328,267	-66,664	1,261,603	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	1,482	1,482	29.00
30.00	Administrative Costs	153,022	159,179	312,201	0	312,201	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	153,022	159,179	312,201	1,482	313,683	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,434,327	206,141	1,640,468	-65,182	1,575,286	32.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2016
To 09/30/2017

Date/Time Prepared:
2/12/2018 1:26 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-29,963	813,694	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	145,685	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	254,338	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	5,486	9.00
10.00	Subtotal (sum of lines 1 through 9)	-29,963	1,219,203	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	12,437	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,437	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-29,963	1,231,640	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-15	1,467	29.00
30.00	Administrative Costs	0	312,201	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15	313,668	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-29,978	1,545,308	32.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period: From 10/01/2016

Worksheet M-1

Component CCN: 14-8557

To 09/30/2017

Date/Time Prepared:
2/12/2018 1:26 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	273,803	0	273,803	-80,495	193,308	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	22,315	0	22,315	0	22,315	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	91,519	0	91,519	0	91,519	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	9,395	9,395	3,098	12,493	9.00
10.00	Subtotal (sum of lines 1 through 9)	387,637	9,395	397,032	-77,397	319,635	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	5,690	5,690	0	5,690	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,690	5,690	0	5,690	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	387,637	15,085	402,722	-77,397	325,325	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	3,232	3,232	25,118	28,350	29.00
30.00	Administrative Costs	28,912	38,672	67,584	0	67,584	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	28,912	41,904	70,816	25,118	95,934	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	416,549	56,989	473,538	-52,279	421,259	32.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2016
To 09/30/2017

Date/Time Prepared:
2/12/2018 1:26 pm

RHC II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	193,308		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	22,315		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	-2,500	89,019		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	12,493		9.00
10.00	Subtotal (sum of lines 1 through 9)	-2,500	317,135		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	5,690		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,690		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-2,500	322,825		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	28,350		29.00
30.00	Administrative Costs	0	67,584		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	95,934		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,500	418,759		32.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2016 To 09/30/2017	Worksheet M-2 Date/Time Prepared: 2/12/2018 1:26 pm
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		RHC I		Cost			
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.48	7,403	4,200	10,416	1.00	
2.00	Physician Assistant	0.00	0	2,100	0	2.00	
3.00	Nurse Practitioner	0.74	1,786	2,100	1,554	3.00	
4.00	Subtotal (sum of lines 1 through 3)	3.22	9,189		11,970	4.00	
5.00	Visiting Nurse	0.00	0			5.00	
6.00	Clinical Psychologist	0.00	0			6.00	
7.00	Clinical Social Worker	0.00	0			7.00	
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02	
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.22	9,189			11,970	
9.00	Physician Services Under Agreements		0			0	
						1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,231,640	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,231,640	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)					313,668	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,227,219	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,540,887	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,540,887	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,540,887	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,772,527	20.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2016 To 09/30/2017	Worksheet M-2 Date/Time Prepared: 2/12/2018 1:26 pm
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		RHC II		Cost		
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.57	2,321	4,200	2,394	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.23	279	2,100	483	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.80	2,600		2,877	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.80	2,600			8.00
9.00	Physician Services Under Agreements		0			9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				322,825	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				322,825	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet, M-1, col. 7, line 31)				95,934	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				137,016	15.00
16.00	Total overhead (sum of lines 14 and 15)				232,950	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				232,950	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				232,950	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				555,775	20.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	RHC I	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,772,527	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		104,707	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,667,820	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,970	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,970	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		222.88	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	222.88	222.88	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,755	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	614,034	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	614,034	16.00
16.01	Total program charges (see instructions)(from contractor's records)		567,641	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,633	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,829	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		439,317	16.04
16.05	Total program cost (see instructions)	0	455,146	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49,059	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		100,790	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		455,146	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		43,357	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		498,503	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	SEQUESTRATION		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		498,503	26.00
26.01	Sequestration adjustment (see instructions)		9,970	26.01
27.00	Interim payments		487,854	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		679	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

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MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/12/2018 1:26 pm	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			555,775	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			20,814	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			534,961	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,877	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,877	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			185.94	7.00
		Calculation of Limit (1)			
				Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)
				1.00	2.00
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			81.32	81.32
9.00	Rate for Program covered visits (see instructions)			185.94	185.94
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		172	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		31,982	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	31,982	16.00
16.01	Total program charges (see instructions)(from contractor's records)			41,818	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			210	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			161	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			22,538	16.04
16.05	Total program cost (see instructions)		0	22,699	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			3,649	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			7,592	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			22,699	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			5,546	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			28,245	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			28,245	26.00
26.01	Sequestration adjustment (see instructions)			565	26.01
27.00	Interim payments			30,709	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)			-3,029	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2			0	30.00

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In Lieu of Form CMS-2552-10

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	RHC I	Cost
		Pneumococcal	Infl uenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,219,203	1,219,203	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001279	0.001128	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,559	1,375	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	35,927	7,653	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	37,486	9,028	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,231,640	1,231,640	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,540,887	1,540,887	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.030436	0.007330	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	46,898	11,295	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	84,384	20,323	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	279	246	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	302.45	82.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	89	199	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	26,918	16,439	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		104,707	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		43,357	16.00

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In Lieu of Form CMS-2552-10

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/12/2018 1:26 pm
		Title XVIII	RHC II	Cost
		Pneumococcal	Infl uenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	317,135	317,135	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001120	0.000732	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	355	232	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	9,660	1,843	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	10,015	2,075	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	322,825	322,825	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	232,950	232,950	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031023	0.006428	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,227	1,497	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	17,242	3,572	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	78	51	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	221.05	70.04	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	35	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,095	2,451	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		20,814	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,546	16.00

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In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1302
Component CCN: 14-8511

Period:
From 10/01/2016
To 09/30/2017

Worksheet M-5
Date/Time Prepared:
2/12/2018 1:26 pm

		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		480,900		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		2.00
3.00	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)				3.00
Program to Provider					
3.01		03/30/2017	6,954		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,954		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		487,854		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		679		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		488,533		7.00
		0	1.00	2.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
8.00	Name of Contractor				8.00

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In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1302
Component CCN: 14-8557

Period:
From 10/01/2016
To 09/30/2017

Worksheet M-5
Date/Time Prepared:
2/12/2018 1:26 pm

		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		4,722	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	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)			3.00
Program to Provider				
3.01		03/30/2017	25,987	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,987	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		30,709	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,029	6.02
7.00	Total Medicare program liability (see instructions)		27,680	7.00
		0		
		Contractor Number	NPR Date (Mo/Day/Yr)	
		1.00	2.00	
8.00	Name of Contractor			8.00