This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1302 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/23/2024 Time: 11:09 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Tra	acy Bauer	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Tracy Bauer			2
3	Signatory Title	CEO CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-35, 503	-114, 996	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER (OTHER)						4.00
5.00	SWING BED - SNF	0	130, 524	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		142, 444		0	10.00
10.01	RURAL HEALTH CLINIC II	0		5, 692		0	10. 01
200.0	TOTAL	0	95, 021	33, 140	0	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

Health Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1302 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1 MEDICAL CENTER DRIVE 1.00 PO Box: 1.00 County: JO DAVIESS 2.00 City: GALENA State: IL Zi p Code: 61036-2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MIDWEST MEDICAL CENTER 141302 99914 02/01/2000 Ν 0 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF MIDWEST MEDICAL CENTER 14Z302 99914 02/01/2000 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF GALENA STAUSS NURSING 146140 99914 02/17/2010 Р N 9.00 Ν HOME 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC MIDWEST HEALTH CLINIC 148511 99914 12/09/2010 N 15.00 N 0 15 00 Hospital -Based Health Clinic - RHC MIDWEST HEALTH CLINIC 148557 99914 07/15/2016 15.01 15.01 0 OF ELIZABETH Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 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) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 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. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 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) 22.02 Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 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.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1302 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/23/2024 11: 09 am XVIII XIX 1. 00 2.00 3.00 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. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 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 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 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 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	MI DWES	ST MEDICAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	LEX IDENTIFICATION DA	ATA Provi der	F	eriod: rom 10/01/2022 o 09/30/2023		pared:
		1	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	O7 dill
C+: FF04 - <del>-</del> + A0A D V	- FTF D: : N		1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			sinis base year	r is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained resident n-primary care all nonprovider d non-primary care n column 3 the rati		0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1 00	2.00	Si te	4.00	E 00	-
65.00 Enter in column 1, if line 63	1. 00	2. 00	3.00	4.00	5. 00 0. 000000	65.00
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)			Unwei ghted	Unwei ghted	Ratio (col.	65.00
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
Cooti on FFO4 - F th- ACA C.	Voor ETE Deelderd '	n Nonneoud des Colle	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setti	ingsEffective i	ror cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit. (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
(cordini i di vi ded by (cordini i i	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00	1. 00	2. 00	3. 00	4. 00	5. 00	(7.00
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. UU

Health Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1302 Peri od: Worksheet S-2 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/23/2024 11:09 am 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 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) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is 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 76.00 0 76.00 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) 1.00 Long Term Care Hospital PPS 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 Ν 81.00 "Y" for yes and "N" for no. 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 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. 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 90.00 Ν Υ yes or "N" for no in the applicable column. 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. 91.00 Ν 91.00 Ν 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. 92.00 Υ 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. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν N applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S Part I Date/Time I	Prepared
			V	2/23/2024 XIX	11:09 am
			1.00	2. 00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and res	idents post	N	Y	98. 0
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the I	reporting of ch	narges on Wks		Y	98. 0
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes	calculation of	observati on	N	Y	98. 0
for title V, and in column 2 for title XIX.  18.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for v	tical access h	nospital (CAH)		N	98. 0
for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i	l reimbursed 10	01% of	N	N	98. 0
in column 2 for title XIX.  P8.05 Does title V or XIX follow Medicare (title XVIII) and add by Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	ack the RCE di	sallowance o	n N	Υ	98. 0
column 2 for title XIX.  28.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			N	Y	98. 0
column 2 for title XIX. Rural Providers					
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of payme	Y Y		105. 0 106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded 1	nn 1. (see ins you train I&F	structions) Rs in an	N		107.0
Enter "Y" for yes or "N" for no in column 2. (see instruct 08.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ions) CRNA fee sche	edul e? See 4.			108. 0
	Physi cal 1.00	0ccupationa 2.00	Speech 3.00	Respirator 4.00	ТУ
09.00 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.		Y Y	N N	N 4.00	109.0
i ,					
, c. , co or it is its is addit that apy.					
	"Y" for yes or	"N" for no.	If yes,	1.00 N	110.0
10.00 Did this hospital participate in the Rural Community Hospi Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no.	If yes, ough 215, as	N	110. C
10.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating ir	Community period? Enter the column 2.	If yes, bugh 215, as		110. C
<ul> <li>10.00 Did this hospital participate in the Rural Community Hospidemonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable.</li> <li>11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is participate in that apply: "A" for Ambulance services; "B" for a</li> </ul>	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating ir	Community period? Ente enter the column 2.	If yes, bugh 215, as	N 2. 00	
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to a integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services.	"Y" for yes or prksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating ir indditional beds alth Model reporting column 1 is pating in the	Community period? Enter the column 2.	If yes, bugh 215, as	N	111. (
<ul> <li>10.00 Did this hospital participate in the Rural Community Hospin Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for a for tele-health services.</li> <li>12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information</li> <li>15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.</li> </ul>	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the cased or "N" for no B, or E only) 93" percent (includes	Community period? Ente enter the column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  In this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this or integration prong of the FCHIP demo in which this CAH is participate in the response to or integration prong of the FCHIP demo in which this CAH is participate in the response to or integration prong of the FCHIP demo in which this CAH is participate in the Pennsyl vania Rural Health apply: "A" for Ambulance services; "B" for a for tele-health services.  In the response to or integration of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If or "Y", enter in column 2, the date the hospital began particity demonstration. In column 3, enter the date the hospital control participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  In column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1.  In the current cost reporting Information and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) 93" percent (includes ers) based on	Community period? Ente enter the n column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	111. C
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is participate in the pennsyl vania Rural Health that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsyl vania Rural Health (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began particity demonstration. In column 3, enter the date the hospital context participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	"Y" for yes or orksheet E-2, I the Frontier Cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the based or "N" for no B, or E only) 93" percent (includes ers) based on for yes or urance? Enter	Community period? Ente enter the column 2. s; and/or "C"  1.00  N	If yes, bugh 215, as	N 2. 00	111. (

Health Financial Systems	MI DWEST		L CENTER			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	4	Provi der CC	CN: 14-1302		riod: om 10/01/2022 09/30/2023		epared:
							1.00	$\dashv$
147.00 Was there a change in the statist	ical basis? Enter "Y"	for ve	s or "N" for	no.			N N	147.00
148.00 Was there a change in the order o							N	148.00
149.00 Was there a change to the simplif	ied cost finding metho	od? Ent					N	149. 00
			Part A	Part		Title V	Title XIX	
December 6 and 1 a			1.00	2.00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal	N TOT TIO TOT EACT C	olliportei	Y	Y and Fairt	В. (	N	N N	155.00
156. 00 Subprovi der - IPF			N	l 'n	1	N	N	156. 00
157. 00 Subprovi der - IRF			N	N N	1	N	N	157. 00
158. 00 SUBPROVI DER					1			158.00
159. 00 SNF			N	N	]	N	N	159.00
160.00 HOME HEALTH AGENCY			N	N N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1. 00	
Mul ti campus								
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in di	ffere	ent CBSAs?	N	165. 00
	Name		County	State	Zip (		FTE/Campus	
	0		1. 00	2. 00	3. 0	00 4.00	5. 00	
166.00  f 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)							0.0	00 166. 00
							1. 00	
Health Information Technology (HI	T) incentive in the A	meri car	n Recovery ar	nd Rei nves	tment	Act		
167.00 s this provider a meaningful use 168.00 f this provider is a CAH (line 1	05 is "Y") and is a me	eani ngf	ul user (lin			enter the	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user,	, does	this provide			a hardshi p		168. 0
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")					l"), enter the	0.0	00169.00
13. 22. 1. 2 1. 23.0 (333 1311 4011	,					Begi nni ng	Endi ng	
						1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ding da	ite for the r	eporti ng				170.00
						1. 00	2. 00	
171.00  fline 167 is "Y", does this pro	vider have any days fo	or indi	vi dual s enro	lled in		N N	2.00	0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I	, line 2, co	I. 6? Ente				

Health Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1302 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 2/23/2024 11:09 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 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) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 02/19/2024 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Υ 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper. 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 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 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 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) Was the cost report prepared using the PS&R Report for 17.00 Υ 11/14/2023 Υ 11/14/2023 17.00 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) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N 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. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems MIDWEST MEDIC		CN. 14 1202		u of Form CMS		
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S Part II Date/Time P 2/23/2024 1	repared:	
		Descr	ipti on	Y/N	Y/N		
			)	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		
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21.00	
21.00	records? If yes, see instructions.	IN		IN IN		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.				N	23. 0	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	9			N	24.0	
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	Υ	25. 0	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	e cost report	ing period?	If yes, see	N	26. 0	
27. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27. 0	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into du	ring the cos	t reporting	Y	28. 0	
29. 00							
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see	N	30.0	
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If ye	s, see	N	31.0	
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.0	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33. 0	
	Provi der-Based Physi ci ans						
	Were services furnished at the provider facility under an a lf yes, see instructions.	· ·	·	. ,	Y	34.0	
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	sting agreeme structions.	nts with the	provi der-based	N	35. C	
				Y/N	Date		
	Homo Offi on Costs			1.00	2. 00		
36 UU	Home Office Costs Were home office costs claimed on the cost report?			N		36.0	
37 NN	If line 36 is yes, has a home office cost statement been pr	enared by the	home office			37.0	
	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off	. ,				38.0	
	the provider? If yes, enter in column 2 the fiscal year end	of the home	offi ce.			39.0	
10. 00	see instructions.  If line 36 is yes, did the provider render services to the	•	,			40.0	
.5. 50	instructions.		303, 300	14		70.0	
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
11. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D		GOODMAN		41.0	
42. 00		WIPFLI LLP				42.0	
	preparer.					II.	

Health Financial Systems	MI DWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSE	MENT QUESTIONNAIRE	Provi der (		Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Pre	
				10 07/30/2023	2/23/2024 11:	09 am
		3	. 00			
Cost Report Preparer Contact Informat	i on					
41.00 Enter the first name, last name and	he title/position	CPA				41.00
held by the cost report preparer in o	columns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	e cost report					42.00
preparer.						
43.00 Enter the telephone number and email	address of the cost					43.00
report preparer in columns 1 and 2, i	especti vel y.					

Period: Worksheet S-3
From 10/01/2022 Part I
To 09/30/2023 Parte/Time Propagad Health Financial SystemsMIDWESHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 14-1302

						o 09/30/2023	Date/Time Pre 2/23/2024 11:	
							I/P Days /	O7 dill
							0/P Visits /	
							Tri ps	
	Component	Worksheet A Line No.	No.	. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1. 00		2. 00	3.00	4.00	5. 00	
	PART I - STATISTICAL DATA				•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25	9, 125	16, 472. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
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 6. 00	Hospital Adults & Peds. Swing Bed SNF						0 0	5. 00 6. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			25	9, 125	16, 472. 00		7.00
7.00	beds) (see instructions)			23	9, 123	10,472.00	U	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	16, 472. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17.00
18. 00	SUBPROVI DER	42. 00		0			0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		5	1, 825	5	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 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE							23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
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)	07.00		82				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance 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	(			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges	20		_1			_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	1	0	(	ון	0	34.00

Provi der CCN: 14-1302

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: 2/23/2024 | 11:09 am

						2/23/2024 11:	09 am
		I/P Days	3 / O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
			7.00	Pati ents	& Residents	Payrol I	
	DART I CTATICTICAL DATA	6. 00	7. 00	8. 00	9. 00	10.00	
4 00	PART I - STATISTICAL DATA		20	70/			4 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	500	32	786			1.00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	101	0				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1, 183	0	1, 445			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	1, 103	0	143			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 683	32	2, 374			7.00
7.00	beds) (see instructions)	1,000	02	2,071			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, 683	32	2, 374	0.00	119. 42	14.00
15.00	CAH vi si ts	7, 360	0	26, 426			15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER		0	C	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY	0	0	C	0.00	2. 97	
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE			15, 685	0.00	42. 01	1
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC	0.500		0.050		44.04	25.00
26.00	RURAL HEALTH CLINIC	2, 522	0	9, 958		14. 94	1
26. 01	RURAL HEALTH CLINIC II	599	0	3, 343			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	Total (sum of lines 14-26)		0	2.42	0. 00	184. 12	
28. 00	Observation Bed Days		0	243			28.00
29. 00 30. 00	Ambulance Trips	0		C			29.00
	Employee discount days (see instruction)			C			30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)	0	0	C			32.00
		١	U	C			
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges						33. 00
	Temporary Expansi on COVID-19 PHE Acute Care		0	C			34.00
5 7. 00	1.5po. ary Expansion Sourb 17 the Acute Care	١	O		1 1	ı	1 5 1. 00

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part I | Date/Time | Prepared: Provider CCN: 14-1302

				To	09/30/2023	Date/Time Pre 2/23/2024 11:	
		Full Time		Di sch	arges	2/23/2024 11.	07 4111
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	141	16	199	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			28	0		2.00
3. 00	HMO IPF Subprovider			20	0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ŭ.		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
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	141	16	199	
15.00	CAH visits						15.00
15. 10							15. 10
16.00	SUBPROVIDER - I PF						16.00
17. 00 18. 00		0.00	0		0	0	17. 00 18. 00
19. 00	SKILLED NURSING FACILITY	0.00	U		U	U	19.00
20.00	NURSING FACILITY	0.00					20.00
21. 00		0.00				53	
22. 00		0.00				00	22. 00
23. 00							23. 00
24. 00	, ,						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25		0. 00					26. 25
27. 00		0.00					27. 00
28. 00	3						28. 00
29. 00	·						29.00
30.00	Employee discount days (see instruction)						30.00
31.00							31.00
32.00	3 3 1						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	,						22.00
				(1)	Į.		
33. 01	LTCH site neutral days and discharges			0			33. 00 33. 01

	Financial Systems  TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 14-1302	Peri od:	eu of Form CM Worksheet		
			Component	CCN: 14-8511	From 10/01/2022 To 09/30/2023			
					RHC I	Cos		J9 all
	Clinic Address and Identification					. 00		
. 00	Street		1		ONE MEDICAL CI			1. (
				00	State 2.00	ZIP Code 3.00		
2. 00	City, State, ZIP Code, County		GALENA	. 00		61036		2. (
	,							
	LIOSDITAL BASED FOLICE ONLY. Decimention Est	on "D" for nun	al an "II" fan	unhan		1.00	0	2 (
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for fur	ai or u ror		nt Award	Date	U	3. (
					1. 00	2. 00		
	Source of Federal Funds	A . 1		1		T		
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						ŀ	4. 0 5. 0
5. 00	Health Services for the Homeless (Section 34						İ	6. 0
. 00	Appalachian Regional Commission						l	7. (
. 00 . 00	Look-Alikes OTHER (SPECIFY)						ŀ	8. ( 9. (
. 00	OTTLER (SPECIFI)						l	9.
. 02							l	9.
. 03							l	9.
. 04 . 05							ŀ	9. 9.
. 06							i	9.
. 07								9.
. 08								9.
. 09 . 10							ŀ	9. ( 9. <sup>-</sup>
0. 00	Door this facility energts as other than a h	aani tal baaad	DUC on FOUCA F	nton "V" for	1. 00 N	2. 00	0	10.0
0.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column				10. (
	nour s. )	Sun	iday	N	londay	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00		
1. 00	CLINIC			07: 30	17: 00	07: 30		11. 0
					1. 00	2.00		
2. 00	Have you received an approval for an excepti				Y			12. (
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N		0	13.0
	number of providers included in this report.							
	numbers below.							
					der name	CCN		
4. 00	RHC/FQHC name, CCN				1. 00	2. 00		14. 0
		Y/N	V	XVIII	XIX	Total Visi	ts	
F 60	10	1. 00	2. 00	3.00	4. 00	5. 00		45
5.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in							15. (
	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							

Health Financial Systems	MI DWEST MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 14-1302	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8511	From 10/01/2022 To 09/30/2023		epared: 09 am_
				RHC I	Cost	
		Со	unty			
		4	. 00			
2.00 City, State, ZIP Code, County		JO DAVIESS				2.00
	Tuesday	Wedr	nesday	Thursday		
	to	from	to	from	to	
	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	17: 00	11.00
	Fri	day	Sa	nturday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	07: 30	17: 00	08: 00	12: 00		11.00

Heal th	n Financial Systems	MI DWEST MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1302	Peri od:	Worksheet S-8	3
			Component	CCN: 14-8557	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/23/2024 11:	
					RHC II	Cost	
					1	00	4
	Clinic Address and Identification					00	
1. 00	Street		1		560 PLEASANT S		1.00
				00	2. 00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		ELI ZABETH	00		61028	2.00
	1		<u> </u>				
2 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urbon		1.00	3 00
3. 00	HOSPITAL-BASED FUNCS UNLY: DESIGNATION - ENT	er k for fur	al of U for	1	nt Award	Date	3.00
				014	1. 00	2. 00	
	Source of Federal Funds						
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on	( . ) , ,					7.00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00	j 1					0	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	or other operat	ion(s) and the	operating			
	Thou 3. )	Sun	day		Monday	Tuesday	
		from	to	from	to	from	
	Facility bours of energtions (1)	1. 00	2. 00	3.00	4. 00	5. 00	-
11. 00	Facility hours of operations (1)			07: 30	17: 00	07: 30	11.00
		•	<b>'</b>				
10.00	The second of th			10	1.00	2. 00	10.00
12. 00 13. 00					N N	0	12.00
13.00	30. 8? Enter "Y" for yes or "N" for no in col				11		15.00
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Prov	ider name	CCN	
				1100	1. 00	2. 00	
14. 00	RHC/FQHC name, CCN						14.00
		Y/N	V 2.00	XVIII	XIX	Total Visits	
15. 00	Have you provided all or substantially all	1. 00	2. 00	3. 00	4.00	5. 00	15.00
13.00	GME cost? Enter "Y" for yes or "N" for no in	1					15.00
	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)		_	L			
				inty 00			
2. 00	City, State, ZIP Code, County		JO DAVIESS	00			2.00
	1. J., 2323, 2 2227 Souncy	Tuesday		esday	Thur	sday	1
		to	from	to	from	to	
	Eacility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17: 00	07: 30	17: 00	07: 30	17: 00	11.00
	1020	1	1000	1.7.00	107.00	1 00	1

Health Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 14-1302	Peri od:	Worksheet S-8	i
				From 10/01/2022		
		Component	CCN: 14-8557	To 09/30/2023	Date/Time Pre 2/23/2024 11:	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	17: 00				11.00

10251 I	Financial Systems MIDWEST MEDICA	_	CN. 14 1202		u of Form CMS-2					
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	JN: 14-1302	Period: From 10/01/2022 To 09/30/2023		pared:				
					1. 00					
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					İ				
1.00	Cost to charge ratio (see instructions)				0. 632510	1.0				
	Medicaid (see instructions for each line)									
2. 00	Net revenue from Medicaid				5, 692, 948	2.0				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			10	Y	3. 0 4. 0				
. 00										
o. 00 o. 00	Medicaid charges		9, 609, 656	5. C						
. 00	Medicald cost (line 1 times line 6)		6, 078, 204	7.0						
. 00	Difference between net revenue and costs for Medicaid progra	m (see instru	uctions)		385, 256					
	Children's Health Insurance Program (CHIP) (see instructions									
. 00	Net revenue from stand-alone CHIP				0	9.0				
0.00	Stand-alone CHIP charges				0	10.0				
1. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.0				
2. 00	Difference between net revenue and costs for stand-alone CHI			`	0	12.0				
2 00	Other state or local government indigent care program (see i				0	1 12 6				
3. 00 4. 00	Net revenue from state or local indigent care program (Not i Charges for patients covered under state or local indigent c			,		13. ( 14. (				
4.00	10)	are program	(NOT THE due	a ili ililes o oi	U	14.				
5. 00	State or local indigent care program cost (line 1 times line	14)			0	15. (				
6. 00			e program (se	ee instructions)	Ö	16. (				
	Grants, donations and total unreimbursed cost for Medicaid,	CHIP and stat	te/local indi	gent care progra	ams (see	ĺ				
	instructions for each line)									
					0					
8. 00	Government grants, appropriations or transfers for support o	f hospital op	perati ons	ms (sum of lines	0	18. (				
8. 00	Government grants, appropriations or transfers for support o Total unreimbursed cost for Medicaid , CHIP and state and Lo	f hospital op	perati ons	ns (sum of lines		18.0				
8. 00	Government grants, appropriations or transfers for support o	f hospital op	perati ons	ns (sum of lines	0	18.0				
8. 00	Government grants, appropriations or transfers for support o Total unreimbursed cost for Medicaid , CHIP and state and Lo	f hospital op	perations care program Uninsured patients	I nsured pati ents	0 385, 256 Total (col. 1 + col. 2)	18.0				
8. 00	Government grants, appropriations or transfers for support o Total unreimbursed cost for Medicaid , CHIP and state and Io 8, 12 and 16)	f hospital op	perations care program Uninsured	Insured	0 385, 256 Total (col. 1	18. (				
8. 00 9. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line)	f hospital op cal indigent	oerati ons care program Uni nsured pati ents 1.00	Insured patients 2.00	0 385, 256 Total (col. 1 + col. 2) 3.00	18. ( 19. (				
8. 00 9. 00 0. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions	f hospital opcal indigent	Derati ons care program  Uni nsured pati ents  1.00	Insured patients 2.00	0 385, 256 Total (col. 1 + col. 2) 3.00	18. ( 19. ( 20. (				
8. 00 9. 00 0. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions for patients approved for charity care and uninsured discounts)	f hospital opcal indigent	oerati ons care program Uni nsured pati ents 1.00	Insured patients 2.00	0 385, 256 Total (col. 1 + col. 2) 3.00	18. 19. 1				
8. 00 9. 00 0. 00 1. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions	f hospital opcal indigent  ns) counts (see	Derati ons care program  Uni nsured pati ents  1.00	Insured patients 2.00	0 385, 256 Total (col. 1 + col. 2) 3. 00 224, 351 203, 359	18. ( 19. ( 20. ( 21. (				
8. 00 9. 00 0. 00 1. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writt charity care	f hospital opcal indigent  ns) counts (see	Uninsured patients 1.00 57,1 36,1	I nsured pati ents 2.00  24 167, 227 32 167, 227 0 0	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359	20. ( 21. (				
8. 00 9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care	f hospital opcal indigent  ns) counts (see	Derati ons care program  Uni nsured pati ents  1.00	I nsured pati ents 2.00  24 167, 227 32 167, 227 0 0	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359	20. ( 22. (				
8. 00 9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writt charity care	f hospital opcal indigent  ns) counts (see	Uninsured patients 1.00 57,1 36,1	I nsured pati ents 2.00  24 167, 227 32 167, 227 0 0	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359	20. ( 21. ( 22. (				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)	f hospital opcal indigent  ns) counts (see en off as	Uni nsured pati ents 1.00 57,1 36,1	Insured patients 2.00  24 167,227  0 0  32 167,227	0 385, 256 Total (col. 1 + col. 2) 3. 00 224, 351 203, 359 0 203, 359	20. ( 21. ( 23. (				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patients	f hospital opcal indigent  ns) counts (see en off as	Uni nsured pati ents 1.00 57,1 36,1	Insured patients 2.00  24 167,227  0 0  32 167,227	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359	20. ( 21. ( 23. (				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3. 00 224, 351 203, 359 0 203, 359	20. (c 21. (c 23. (c				
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. ( 21. ( 23. ( 24. ( 25. (				
8. 00 9. 00 0. 00 11. 00 22. 00 13. 00 14. 00 15. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions)	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 25. 0				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. (c 21. (c 23. (c 25. (c 26. (c)				
20. 00 21. 00 22. 00 24. 00 25. 00 27. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions)  Medicare reimbursable bad debts (see instructions)	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. C 21. C 22. C 23. C 24. C 25. C 26. C 27. C				
20. 00 21. 00 22. 00 23. 00 25. 01 26. 00 27. 01	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	ns) counts (see en off as  nt days beyon re program?	Uninsured patients 1.00 57,1 36,1	Insured patients 2.00  24 167,227 32 167,227 0 0 32 167,227 of stay limit	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. C 21. C 22. C 23. C 25. C 26. C 27. C				
20. 00 21. 00 22. 00 24. 00 25. 01 26. 01 27. 01 28. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent callf line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	ns) counts (see en off as  nt days beyon re program? the indigen	Uninsured patients 1.00 57,1 36,1 and a Length of tears progra	Insured patients 2.00  24 167, 227  29 167, 227  0 0  32 167, 227  of stay limit  am's length of	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N 0 498, 141	20. ( 21. ( 22. ( 23. ( 25. ( 25. ( 26. ( 27. ( 28. ( 28. ( 28. ( 28. ( 29. (				
20. 00 21. 00 22. 00 23. 00 25. 01 26. 00 27. 01 28. 00 29. 00 30. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions Cost of patients approved for charity care and uninsured disinstructions) Payments received from patients for amounts previously writt charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patie imposed on patients covered by Medicaid or other indigent called line 24 is yes, enter the charges for patient days beyond stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt	ns) counts (see en off as  nt days beyon re program? the indigen	Uninsured patients 1.00 57,1 36,1 and a Length of tears progra	Insured patients 2.00  24 167, 227  29 167, 227  0 0  32 167, 227  of stay limit  am's length of	0 385, 256 Total (col. 1 + col. 2) 3.00 224, 351 203, 359 0 203, 359 1.00 N	20. (21. (22. (23. (25. (25. (27. (27. (27. (29. (29. (29. (29. (29. (29. (29. (29				

OSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	CCN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023		epare
				1. 00	
PART II - HOSPITAL DATA					-
Uncompensated and Indigent Care Cost-to-Charg	e Ratio				1
OO Cost to charge ratio (see instructions)					1
Medicaid (see instructions for each line)					1
00 Net revenue from Medicaid					2
OO Did you receive DSH or supplemental payments	from Medicaid?				3
00 If line 3 is yes, does line 2 include all DSH	l and/or supplemental paymen	its from Medi	cai d?		4
00   If line 4 is no, then enter DSH and/or supple	emental payments from Medica	i d			5
00 Medicaid charges					6
00 Medicaid cost (line 1 times line 6)					7
Difference between net revenue and costs for					8
Children's Health Insurance Program (CHIP) (s	ee instructions for each li	ne)			4
Net revenue from stand-alone CHIP					9
00 Stand-alone CHIP charges					10
00 Stand-alone CHIP cost (line 1 times line 10)					11
.00 Difference between net revenue and costs for			`		12
Other state or local government indigent care					4
Net revenue from state or local indigent care					13
.00 Charges for patients covered under state or I	ocai indigent care program	(Not include	a in lines 6 or		14
10) .00   State or Local indigent care program cost (Li	no 1 timos lino 14)				15
.00 State or local indigent care program cost (li .00 Difference between net revenue and costs for		o program (e	oo instructions)		16
Grants, donations and total unreimbursed cost				ims (see	1 10
instructions for each line)	To Medicard, officially sta	terrocar rna	rgent care progre	11113 (300	
.00 Private grants, donations, or endowment incom	ne restricted to funding cha	ri tv care			1 17
.00 Government grants, appropriations or transfer					18
.00 Total unreimbursed cost for Medicaid , CHIP a			ms (sum of lines		19
8, 12 and 16)					
		Uni nsured		Total (col. 1	
		patients	pati ents	+ col . 2)	1
Harris Constitution Constitution Cons	and David	1.00	2. 00	3. 00	+
Uncompensated care cost (see instructions for	·	T			٠,
On Charity care charges and uninsured discounts Cost of patients approved for charity care an					20
instructions)	id utilitisui ed di scoulits (see				21
.00 Payments received from patients for amounts p	reviously written off as				22
charity care	neviously written or as				~~
.00 Cost of charity care (see instructions)					23
too joost of chartey care (ood thoth dott only)					1
				1. 00	
00 Does the amount on line 20 col. 2, include ch	arges for patient days beyo	nd a Length	of stay limit		24
imposed on patients covered by Medicaid or ot	her indigent care program?	J	•		
00 If line 24 is yes, enter the charges for pati		it care progr	am's Length of		25
stay limit	-		-		
01 Charges for insured patients' liability (see	instructions)				25
00 Bad debt amount (see instructions)					26
.00 Medicare reimbursable bad debts (see instruct					27
.01 Medicare allowable bad debts (see instruction	,				27
3 00 Non-Medicare bad debt amount (see instruction	(2)				1 28

28. 00 29. 00 30. 00

31.00

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MIDWEST MEDICA	Provider CO	CN: 14 1202 [	Peri od:	Worksheet A	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provider Co		rom 10/01/2022		
				1	Го 09/30/2023		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	2/23/2024 11: Reclassi fi ed	09 alli
	out conton passing their	00.0.700	0 11.01	+ col . 2)	i ons (See	Tri al Bal ance	
				,	A-6)	(col. 3 +-	
						col. 4)	
	OFNEDAL CEDIU OF COCT OFNEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  OO100 NEW CAP REL COSTS-BLDG & FIXT		1, 278, 762	1, 278, 762	-1, 273, 363	5, 399	1.00
1. 01	00101 NEW CAP REL COSTS-ALU BLDG		1, 270, 702	1,270,702		52, 816	1.00
1. 02	00102 NEW CAP REL COSTS-2007 HOSPITAL		0	ď	2, 403, 009	2, 403, 009	1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB		0	(	0	0	1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		854, 233			11, 886	2.00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0		1, -= 1, - 1	1, 024, 349	2.01
3. 00 4. 00	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 788, 961	3, 788, 96°	٥	0 3, 597, 764	3. 00 4. 00
5. 01	00570 ADMITTING	489, 615	9, 178			498, 793	5. 01
5. 02	00550 I NFORMATI ON TECHNOLOGY	345, 111	479, 923			825, 034	5.02
5.03	00590 HOSPITAL BILLING	0	0	. (	453, 739	453, 739	5. 03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL	835, 786	2, 271, 288	3, 107, 074	-706, 822	2, 400, 252	5. 04
6.00	00600 MAI NTENANCE & REPAI RS	0	0	(	0	0	6.00
7.00	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-SCC	155, 289	609, 801	765, 090		765, 090	7.00
7. 01 8. 00	00800 LAUNDRY & LINEN SERVICE	98, 666 0	215, 450 88, 180			314, 116 88, 180	7. 01 8. 00
8. 01	00801 LAUNDRY & LINEN SERVICE-SCC	0	32, 813			32, 813	8. 01
9. 00	00900 HOUSEKEEPI NG	238, 607	46, 176			284, 783	9.00
9. 01	00901 HOUSEKEEPI NG-SCC	92, 634	22, 051	114, 685		114, 685	9. 01
10.00	01000 DI ETARY	308, 137	199, 615	507, 752	0	507, 752	10.00
10. 01	01001 DI ETARY-SCC	333, 861	291, 345	625, 206	86, 311	711, 517	10. 01
11.00	01100 CAFETERI A	0	0	(	0	0	11.00
11. 01	01101 CAFETERI A-SCC 01300 NURSI NG ADMI NI STRATI ON	305 030	10.070	404 709	0	404 700	11.01
13. 00 14. 00	01400 CENTRAL SERVICE & SUPPLY	395, 838 116, 226	10, 870 16, 065			406, 708 132, 291	13. 00 14. 00
15. 00	01500 PHARMACY	0	10, 009	132,27		132, 271	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	252, 565	19, 879	272, 444	1 0	272, 444	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	525, 962	45, 131	571, 093	0	571, 093	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 129, 322	130, 236			1, 377, 280	30.00
42. 00 44. 00	04200 SUBPROVI DER 04400 SKILLED NURSING FACILITY	0	0		0 14, 805	0 14, 805	42. 00 44. 00
46.00	04400 OTHER LONG TERM CARE	1, 894, 857	610, 305	2, 505, 162	· ·	2, 642, 662	46.00
10.00	ANCILLARY SERVICE COST CENTERS	1,071,007	0.0,000	2,000,101	1077000	2/012/002	10.00
50.00	05000 OPERATING ROOM	514, 068	401, 121	915, 189	145, 973	1, 061, 162	50.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	472, 300	1, 121, 868	1, 594, 168	19, 400	1, 613, 568	54.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	57. 00 58. 00
60.00	06000 LABORATORY	422, 853	675, 968	1, 098, 82	0	1, 098, 821	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	38, 048			38, 048	64.00
65.00	06500 RESPIRATORY THERAPY	103, 797	63, 401			57, 296	65.00
	06600 PHYSI CAL THERAPY	1, 643, 850	123, 880	1, 767, 730		1, 725, 358	
66. 01	06601 CARDI AC REHAB	0	0	(	144, 277	144, 277	66. 01
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	106, 231 90, 839	23, 604 8, 584	129, 835 99, 423		159, 127 99, 423	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	90, 839	0, 304	99, 423	0	99, 423	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	1, 079, 335	1, 079, 335	0	1, 079, 335	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 772, 203			1, 772, 203	73.00
76. 00	03020 SLEEP LAB	947, 415	72, 369	1, 019, 784	-1, 019, 784	0	76.00
76. 01	03950 PAIN CLINIC / SERVICE	0	0	(	0	0	76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY OUTPATIENT SERVICE COST CENTERS	0	0		)  0	0	76. 02
88. 00	08800 RURAL HEALTH CLINIC	1, 857, 744	233, 848	2, 091, 592	-51, 479	2, 040, 113	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	558, 194	71, 789				88. 01
90.00	09000 CLI NI C	0	841, 024				90.00
	1 1	542, 386	1, 969, 912			2, 512, 298	91.00
91.00	09100 EMERGENCY	,					92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	0	0	(	0	0	93.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS		1 270 702	1 270 703	1 270 702		
92. 00 93. 00 113. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	1, 270, 792 20, 788, 008			0	113. 00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 0 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)		1, 270, 792 20, 788, 008				113. 00
92. 00 93. 00 113. 00 118. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0				0 35, 344, 322	113. 00 118. 00
92. 00 93. 00 113. 00 118. 00 190. 00 192. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0		35, 260, 16	84, 161	0 35, 344, 322 0 0	113. 00 118. 00 190. 00 192. 00
92. 00 93. 00 113. 00 118. 00 190. 00 192. 00 192. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MIDWEST MEDICAL CLINIC	14, 472, 153	20, 788, 008	35, 260, 16	84, 161	0 35, 344, 322 0 0 0	190. 00 192. 00 192. 01
92. 00 93. 00 113. 00 118. 00 190. 00 192. 00 192. 01 194. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MIDWEST MEDICAL CLINIC 07950 OTHER NONREI MBURSABLE	14, 472, 153 0 0 0 0	20, 788, 008 0 27, 399 0 0	35, 260, 16 <sup>2</sup>	84, 161 0 0 -27, 399 0 0	0 35, 344, 322 0 0 0	113. 00 118. 00 190. 00 192. 00 192. 01 194. 00
92. 00 93. 00 113. 00 118. 00 190. 00 192. 00 194. 00 194. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 019200 PHYSICIANS' PRIVATE OFFICES 19201 MIDWEST MEDICAL CLINIC 07950 OTHER NONREIMBURSABLE 07951 ASSISTED LIVING UNITS	14, 472, 153	20, 788, 008	35, 260, 16 <sup>2</sup>	84, 161 0 0 9 -27, 399 0 0	0 35, 344, 322 0 0 0 0 447, 872	113. 00 118. 00 190. 00 192. 00 192. 01 194. 00 194. 01
92. 00 93. 00 113. 00 118. 00 190. 00 192. 00 194. 00 194. 01 194. 02	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MIDWEST MEDICAL CLINIC 07950 OTHER NONREI MBURSABLE	14, 472, 153 0 0 0 0	20, 788, 008 0 27, 399 0 0	35, 260, 16 <sup>2</sup>	84, 161 0 -27, 399 0 0 0 0 0 -69, 842 0 0	0 35, 344, 322 0 0 0 0 447, 872 0	113. 00 118. 00 190. 00 192. 00 192. 01 194. 00

Heal th Financ	cial Systems	MIDWEST MEDIC	CAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 10/01/2022 To 09/30/2023	Date/Time Pre	paradi
						2/23/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
194. 04 07954	IDLE SPACE	0	0	(	0	0	194. 04
194. 05 07955	COMMUNITY FITNESS CENTER	0	0		13, 080	13, 080	194. 05
200.00	TOTAL (SUM OF LINES 118 through 199)	14, 880, 427	20, 924, 847	35, 805, 27	4 0	35, 805, 274	200.00

 Health Financial
 Systems
 MIDWEST M

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 14-1302 | Peri od: From 10/01/202

Peri od: Worksheet A From 10/01/2022 To 09/30/2023 Date/Time Prepared:

				2/23/2024 11:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		, 00	Allocation	_	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	0	5, 399		1.00
1. 01	00101 NEW CAP REL COSTS-ALU BLDG	Ö		1	1.01
1. 02	00102 NEW CAP REL COSTS-2007 HOSPITAL	-55, 121	1	1	1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB	0			1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	11, 886		2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-12, 385	1, 011, 964	1	2. 01
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 597, 764	1	4.00
5. 01	00570 ADMI TTI NG	0	498, 793	3	5. 01
5. 02	00550 I NFORMATION TECHNOLOGY	0	,	1	5. 02
5. 03	00590 HOSPI TAL BILLING	-60, 284		1	5. 03
5. 04	00540 OTHER ADMINISTRATIVE AND GENERAL	-485, 565		1	5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	0	0		6.00
7.00	00700 OPERATION OF PLANT	-8, 090		1	7.00
7. 01	00701 OPERATION OF PLANT-SCC	-12, 350		1	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0		1	8.00
8. 01	00801 LAUNDRY & LI NEN SERVI CE-SCC	0		1	8. 01
9. 00 9. 01	00900   HOUSEKEEPI NG   00901   HOUSEKEEPI NG-SCC	0	,	1	9. 00 9. 01
10.00	01000 DI ETARY	0 -89, 618	.,	1	10.00
10. 00	01001 DI ETARY	-122, 841	588, 676	1	10.00
11. 00	01100 CAFETERI A	-122, 041	0 300,070	1	11.00
11. 00	01101 CAFETERI A-SCC	0	0		11.00
13. 00		0	_		13.00
14. 00	01400 CENTRAL SERVICE & SUPPLY	Ö		1	14.00
15. 00		0		1	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-1, 099	271, 345		16.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0		1	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-17, 537	1, 359, 743	3	30.00
42.00	04200 SUBPROVI DER	0			42.00
44. 00	04400 SKILLED NURSING FACILITY	0	14, 805	1	44.00
46. 00	04600 OTHER LONG TERM CARE	-388, 008	2, 254, 654	1	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-143, 693	917, 469		50.00
53. 00	05300 ANESTHESI OLOGY	-143, 693			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-571, 751	1, 041, 817		54.00
57. 00	05700 CT SCAN	371,731	1,041,017		57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	0	1, 098, 821		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	38, 048		64.00
65.00	06500 RESPIRATORY THERAPY	0		1	65.00
66.00	06600 PHYSI CAL THERAPY	-46, 538			66.00
66. 01	06601 CARDI AC REHAB	0	ľ	1	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	159, 127	7	67.00
68.00		0	99, 423	3	68. 00
	06900 ELECTROCARDI OLOGY	0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 079, 335	5	71.00
72. 00		0	0		72.00
73.00		-974, 871	797, 332	2	73.00
76.00		0	0		76.00
76. 01		0	1		76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY  OUTPATIENT SERVICE COST CENTERS	0	0	J	76. 02
88. 00		-42, 256	1, 997, 857	7	88. 00
88. 01		-2, 500		1	88. 01
90.00		-1, 184, 311		1	90.00
91.00	1	-541, 053			91.00
92. 00					92.00
93.00		0	0		93.00
	SPECIAL PURPOSE COST CENTERS				
	11300   INTEREST EXPENSE	0			113.00
118.00	9 /	-4, 759, 871	30, 584, 451		118.00
	NONREI MBURSABLE COST CENTERS				l
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192.00
	1 19201 MI DWEST MEDI CAL CLI NI C	0	0		192.01
	07950 OTHER NONREIMBURSABLE	0	0		194.00
	107951 ASSISTED LIVING UNITS	0	447, 872		194. 01
	2 07952 ADULT DAY CARE 3 07953 GRANT FUNDED PROGRAMS		0	1	194. 02 194. 03
	407954 IDLE SPACE		0		194. 03
174.0	10170 FIDEL SINGL	1 0	1 0	<b>'</b> I	1174.04

Health Financial Systems	MI DWEST MEDI	CAL CENTER		In Lieu	of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		CN: 14-1302	Peri od: From 10/01/2022	Worksheet A	
					Date/Time Pre	
					2/23/2024 11:	09 am
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7.00				
194. 05 07955 COMMUNITY FITNESS CENTER	0	13, 080				194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-4, 759, 871	31, 045, 403				200.00

In Lieu of Form CMS-2552-10 Health Financial Systems MIDWEST MEDICAL CENTER RECLASSI FI CATI ONS Provider CCN: 14-1302 Peri od: Worksheet A-6

From 10/01/2022 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 - RECLASS ADC AND ALU DIETARY EXPENSE 1.00 DI ETARY-SCC 10.01 86, 311 1.00 ITOTALS 86, 311 C - RECLASS ASSISTED LIVING BUILDING DEP 1.00 NEW CAP REL COSTS-ALU BLDG 48, 631 1.00 **TOTALS** 48, 631 D - RECLASS PT/MOB SPACE DEPRECIATION 1.00 NEW CAP REL COSTS-BLDG & 1.00 0 27, 399 1.00 FI XT 0 27, 399 E - RECLASS NURSING HOME ADMIN AND GEN 1 00 SKILLED NURSING FACILITY 0 1 00 44 00 14,805 2.00 OTHER LONG TERM CARE 15<u>3, 9</u>69 2.00 46.00 **TOTALS** 168, 774 G - RECLASS PHYSICIAN HOSPITAL MED DIRCT 1.00 ADULTS & PEDIATRICS 30.00 11, 523 1, 152 1.00 11, 523 1, 152 H - RECLASS NEW HOSPITAL DEPRECIATION NEW CAP REL COSTS-2007 1.00 1.02 0 1, 259, 877 1.00 HOSPI TAL TOTALS ō 1, 259, 877 J - RECLASS NEW HOSPITAL MME DEPRECI ATN NEW CAP REL COSTS-MVBLE 1.00 2.01 0 843, 973 1.00 EQUIP NEW HO O TOTALS 843, 973 K - RECLASS INTEREST EXPENSE - NEW HOSP 1.00 NEW CAP REL COSTS-2007 1. 02 0 1, 087, 189 1.00 HOSPI TAI NEW CAP REL COSTS-MVBLE 2 00 2 01 0 164, 203 2.00 EQUIP NEW HO 1, 251, 392 0 M - RECLASS PHYSICIAN IP ROUND TIME 1.00 ADULTS & PEDIATRICS 30.00 16, 617 2, 493 1.00 2.00 0.00 2.00 2, 493 TOTALS 1<del>6, 6</del>17 P - RECLASS PHYSICIAN BENEFITS RURAL HEALTH CLINIC 1.00 88.00 119, 359 1.00 2.00 RURAL HEALTH CLINIC II 88.01 3<u>6, 4</u>07 2.00 TOTALS ō 155, 766 U - RECLASS COMMUNITY FITNESS CTR USE 1.00 COMMUNITY FITNESS CENTER 194.05 12, 310 770 1.00 2.00 OCCUPATI ONAL THERAPY <u>67.</u>00 27, 668 1,624 2.00 TOTALS 39 978 2, 394 X - RECLASS SURGEON FEES 1.00 OPERATING ROOM 50.00 137, 937 1.00 **TOTALS** 137, 937 Y - RECLASS PROPERTY INSURANCE EXP 1.00 OTHER CAPITAL RELATED COSTS 3. 00 8<u>5, 6</u>73 1.00 85, 673 AA - RECLASS CLINIC MGR TIME TO HOSP/NH 5. 04 1.00 OTHER ADMINISTRATIVE AND 1, 364 0 1.00 GENERAL RURAL HEALTH CLINIC II 10, 913 2.00 2.00 88.01 TOTALS 12, 277 0 BB - RECLASS SR CARE ADMINISTRATOR TIME 1.00 ASSISTED LIVING UNITS 16, 469 1.00 0 16, 469 FF - RECLASS EXPENSES TO MATCH REVENUES 1.00 0.00 0 1.00 0 HH - RECLASS HOSP MED DIRECTOR TIME 1.00 ADULTS & PEDIATRICS 30.00 75, 591 10, 346 1.00 CARDI AC REHAB 2.00 <u>66.</u>01 30, 237 4, 138 2.00 TOTALS 105, 828 14, 484 JJ - RECLASS CAP LEASE INTEREST EXPENSE RADI OLOGY-DI AGNOSTI C 19, 400

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19, 400

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1 00

1.00

1.00

54.00

0.00

0.00

TOTALS

TOTALS

TOTALS

MM - RECLASS CLINIC MD SALARY

NN - ENT MD TIME IN OR

1 00

1.00

1.00

Heal th	Financial Systems		MI DWEST MEDI	MIDWEST MEDICAL CENTER			In Lieu of Form CMS-2552-10			
RECLAS	SI FI CATI ONS			Provi der (	CCN: 14-1302	Peri od:	Worksheet A-	6		
						From 10/01/2022 To 09/30/2023	Date/Time Pr 2/23/2024 11			
		Increases								
	Cost Center	Li ne #	Sal ary	0ther						
	2. 00	3.00	4. 00	5. 00						
	PP - RECLASS HOSPITAL BILLING	G EXPENSES								
1.00	HOSPITAL BILLING	5. 03	0	45 <u>3, 7</u> 39	1			1.00		
	TOTALS		0	453, 739						
	QQ - RECLASS CARDIAC REHAB EX	XP								
1.00	CARDI AC REHAB	<u>66.</u> 01	10 <u>3, 7</u> 97	<u>6, 1</u> 05				1.00		
	TOTALS		103, 797	6, 105						
	SS - RECLASS PHYSICIAN SURGE	RY TIME								
1. 00	OPERATING ROOM	50.00	<u>5, 7</u> 56					1.00		
	TOTALS		5, 756	2, 280						
	TT - RECLASS SPECIALTY CLINIC									
1. 00	CLINIC	90. 00	947, 415	72, 369				1.00		
2.00	CLINIC	90.00	0_	3 <u>5, 4</u> 31				2.00		
	TOTALS		947, 415	107, 800						
500.00	Grand Total: Increases		1, 259, 660	4, 675, 580	(			500.00		

| Peri od: | Worksheet A-6 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1302

					10	Date/lime Prepareo 2/23/2024 11:09 an
		Decreases	Callan	0.11	WI . I A 7 D C	
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - RECLASS ADC AND ALU DIETA		8.00	9.00	10.00	
0	ASSISTED LIVING UNITS		0	86, 311	0	1.
-	TOTALS		<del> </del>	86, 311		
	C - RECLASS ASSISTED LIVING I	BUI LDI NG DEP				
0	NEW CAP REL COSTS-BLDG &	1.00	0	48, 631	9	1.
	FIXT					
	TOTALS		0	48, 631		
^	D - RECLASS PT/MOB SPACE DEPL			07.000		
0	PHYSICIANS' PRIVATE OFFICES	192.00	0	2 <u>7, 3</u> 99		1.
	TOTALS  E - RECLASS NURSING HOME ADM	IN AND CEN	U	27, 399		
0	OTHER ADMINISTRATIVE AND	5. 04	O	168, 774	0	1.
U	GENERAL GENERAL	3.04	٥	100, 774		'-
0		0.00	o	0	o	2.
	TOTALS			168, 774		
	G - RECLASS PHYSICIAN HOSPITA	AL MED DIRCT				
0	RURAL HEALTH CLINIC	88. 00	11, 523	1, 152	0	1.
	TOTALS		11, 523	1, 152		
	H - RECLASS NEW HOSPITAL DEPI					
0	NEW CAP REL COSTS-BLDG &	1.00	0	1, 259, 877	9	1.
	FI XT					
	TOTALS		0	1, 259, 877		
^	J - RECLASS NEW HOSPITAL MME			040.070		
0	NEW CAP REL COSTS-MVBLE	2. 00	0	843, 973	9	1.
	EQUI P	++		843, 973	<del> </del>	
	K - RECLASS INTEREST EXPENSE	_ NEW HOSD	UU	043, 973		
0	INTEREST EXPENSE	113.00	ol	1, 251, 392	11	1.
0	THIEREST EXILENSE	0.00	o	0,201,072		2
•	TOTALS — — — —	— <del>- 3.3</del> 5		1, 251, 392		
	M - RECLASS PHYSICIAN IP ROU	ND TIME	-1		· · · · · · · · · · · · · · · · · · ·	
0	RURAL HEALTH CLINIC	88. 00	15, 250	2, 288	0	1
0	RURAL HEALTH CLINIC II	88. 01	1, 367	205	0	2.
	TOTALS		16, 617	2, 493		
	P - RECLASS PHYSICIAN BENEFI					
0	EMPLOYEE BENEFITS DEPARTMENT		0	155, 766		1.
0		0.00	0	0		2.
	TOTALS	C OTD LICE	0	155, 766		
^	U - RECLASS COMMUNITY FITNES:		20.070	2.204		
0	PHYSI CAL THERAPY	66. 00 0. 00	39, 978	2, 394 0	l	1
0	TOTALS — — — —		39, 978	2, 394		2
	X - RECLASS SURGEON FEES		39, 970	2, 394		
0	CLI NI C	90.00	0	137, 937	0	1
0	TOTALS	— <del>70.</del> 00	<del> </del>	13 <u>7, 9</u> 37		'
	Y - RECLASS PROPERTY INSURANG	CE EXP		1077707	l l	
0	OTHER ADMINISTRATIVE AND	5. 04	0	85, 673	12	1
	GENERAL					
	TOTALS		0	85, 673		
	AA - RECLASS CLINIC MGR TIME					
0	RURAL HEALTH CLINIC	88. 00	12, 277	0		1
0		0.00	•	0		2
	TOTALS		12, 277	0		
_	BB - RECLASS SR CARE ADMINIST					_
0	OTHER LONG TERM CARE	46.00	<u> </u>	0		1
	TOTALS	CIL DEVENUES	16, 469	0		
^	FF - RECLASS EXPENSES TO MATO		0			
0	TOTALS — — — —	0.00	_ — — 🖫	0		1
	HH - RECLASS HOSP MED DIRECTO	OD TIME	U U			
0	RURAL HEALTH CLINIC	88.00	105, 828	14, 484	0	1
0	KOKAL HEALIH CEINIC	0.00	103, 020	14, 404		2
_	TOTALS — — — —	— <del></del>	105, 828	14, 484		2
	JJ - RECLASS CAP LEASE INTER	EST EXPENSE	100, 020	17, 704		
0	INTEREST EXPENSE	113. 00	O	19, 400	0	1
-	TOTALS	<u> </u>	<del> </del>	19, 400		'
	MM - RECLASS CLINIC MD SALAR	Y	<u> </u>	. , , 100		
	January States of the States o	0.00	0	0	0	1
0		— — <del></del>	— — <del>ĭ</del> —	- — — <u>ö</u>		'
0	TOTALS					
0	NN - ENT MD TIME IN OR		<u> </u>			
0		0.00	0	0	0	1.

Heal th Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 14-1302 Period: Worksheet A-6
From 10/01/2022 To 09/30/2023 Date/Time Prepared:

					'	2/23/2024 11	
		Decreases		·			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	PP - RECLASS HOSPITAL BILLING	EXPENSES					
1.00	OTHER ADMINISTRATIVE AND	5. 04	0	453, 739	0		1.00
	GENERAL						
	TOTALS		0	453, 739			
	QQ - RECLASS CARDIAC REHAB EX	(P					
1.00	RESPIRATORY THERAPY	<u>65.</u> 00	10 <u>3, 7</u> 97	<u>6, 1</u> 05	0		1.00
	TOTALS		103, 797	6, 105			
	SS - RECLASS PHYSICIAN SURGER	RY TIME					
1.00	RURAL HEALTH CLINIC	8800	<u>5, 7</u> 56		0		1.00
	TOTALS		5, 756	2, 280			
	TT - RECLASS SPECIALTY CLINIC	EXPENSES					
1.00	SLEEP LAB	76. 00	947, 415	72, 369	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0_	35, 431	0		2.00
	TOTALS		947, 415	107, 800			
500.00	Grand Total: Decreases		1, 259, 660	4, 675, 580			500.00

					То	09/30/2023	Date/Time Prep 2/23/2024 11:0	pared: 09 am
	·			Acqui si ti ons	;			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	448, 597	0		0	0	0	1.00
2.00	Land Improvements	4, 011, 958	0		0	0	0	2.00
3.00	Buildings and Fixtures	38, 884, 414	207, 680		0	207, 680	9, 725	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	8, 694, 652	1, 404, 049		0	1, 404, 049	352, 013	6.00
7.00	HIT designated Assets	2, 805, 803	25, 795		0	25, 795	58, 745	7.00
8.00	Subtotal (sum of lines 1-7)	54, 845, 424	1, 637, 524		0	1, 637, 524	420, 483	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	54, 845, 424	1, 637, 524		0	1, 637, 524	420, 483	10.00
		Endi ng	Ful I y					
		Bal ance	Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	448, 597	0					1.00
2.00	Land Improvements	4, 011, 958	0					2.00
3.00	Buildings and Fixtures	39, 082, 369	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6. 00	Movable Equipment	9, 746, 688	0					6.00
7. 00	HIT designated Assets	2, 772, 853	0					7.00
8.00	Subtotal (sum of lines 1-7)	56, 062, 465	0					8.00
9.00	Reconciling Items	0	0					9.00
10. 00	Total (line 8 minus line 9)	56, 062, 465	0					10.00

| Peri od: | Worksheet A-7 |
| From 10/01/2022 | Part | I |
| To 09/30/2023 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MIDWEST MEDICAL CENTER Provider CCN: 14-1302

					10 09/30/2023	Date/lime Pre 2/23/2024 11:	
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	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 WOR		N 2, LINES 1 a	and 2			
1. 00	NEW CAP REL COSTS-BLDG & FIXT	1, 278, 762	0		0	0	1. 00
1. 01	NEW CAP REL COSTS-ALU BLDG	0	0		0	0	1. 01
1. 02	NEW CAP REL COSTS-2007 HOSPITAL	0	0		0	0	1.02
1. 03	NEW CAP REL COSTS ANVELS FOLL D	054 222	0		0	0	1.03
2. 00 2. 01	NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW HO	854, 233	0		0	0	2. 00 2. 01
3. 00	Total (sum of lines 1-2)	2, 132, 995	0		0	0	3. 00
		SUMMARY OF					
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at					
		ed Costs (see Sinstructions)	9 through 14)				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 278, 762				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	854, 233				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, 132, 995				3. 00

Heal th	Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 10/01/2022 To 09/30/2023	Worksheet A-7 Part III Date/Time Pre 2/23/2024 11:	pared:
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed 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 C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 895, 156	0	4, 895, 156	0. 090408	7, 746	1.00
1. 01	NEW CAP REL COSTS-ALU BLDG	2, 644, 777	0	2, 644, 777			1.01
1. 02	NEW CAP REL COSTS-2007 HOSPITAL	35, 356, 441	0	35, 356, 44	0. 652990	55, 943	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	(	0. 000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 027, 734	0	1, 027, 734	0. 018981	1, 626	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	10, 472, 720	251, 408	10, 221, 312	0. 188775		2.01
3.00	Total (sum of lines 1-2)	54, 396, 828					3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relat ed 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 C	ENTERS		•			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	7, 746		0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	4, 185		0	1.01
1. 02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	55, 943	1, 259, 877	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	(	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1, 626		0	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	16, 173		0	2. 01
3.00	Total (sum of lines 1-2)	0	0	85, 673		0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see		

11. 00

1, 032, 068

152, 242

1, 184, 310

0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT
NEW CAP REL COSTS-ALU BLDG

NEW CAP REL COSTS-2007 HOSPITAL

NEW CAP REL COSTS-MVBLE EQUIP NEW HO

NEW CAP REL COSTS-2007 MOB

Total (sum of lines 1-2)

NEW CAP REL COSTS-MVBLE EQUIP

instructions)

14.00

15.00

5, 399

0

52, 816

11, 886

2, 347, 888

1, 011, 964

3, 429, 953

1.00

1.01

1.02

1.03

2.00

2.01

3.00

13.00

12. 00

7, 746 4, 185 55, 943

1, 626

16, 173

85, 673

1.00

1.01

1.02

1.03

2.00

2.01

3.00

	WENTS TO EXPENSES			Provider CCN. 14-1302	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/23/2024 11:	pared:
			Т	Expense Classification o o/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	<pre>Investment income - NEW CAP REL COSTS-BLDG &amp; FIXT (chapter 2)</pre>			EW CAP REL COSTS-BLDG & IXT	1.00	0	1. 00
1. 01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)		ON	EW CAP REL COSTS-ALU BLDG	1. 01	0	1. 01
1. 02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL	В		EW CAP REL COSTS-2007 OSPITAL	1. 02	11	1. 02
1. 03	(chapter 2) Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)		ON	EW CAP REL COSTS-2007 MOB	1. 03	0	1. 03
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			EW CAP REL COSTS-MVBLE QUIP	2. 00	0	2. 00
2. 01	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO	В		EW CAP REL COSTS-MVBLE QUIP NEW HO	2. 01	11	2. 01
3. 00	(chapter 2) Investment income - other	В	-1, 413 R	ADI OLOGY-DI AGNOSTI C	54. 00	0	3. 00
4. 00	(chapter 2) 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)	В	-6, 090 0	PERATION 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 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -2, 456, 932		0. 00	O O	9. 00 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 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -89, 618 D	LETADV	0. 00 10. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others	Б	-09,0100	TETAKT	0.00	0	
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	В	-1, 099 M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.) Vending machines		O		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		О		0.00	O	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation (chapter 21)		0 *	** Cost Center Deleted ***	114.00		25. 00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Date/Time Prepared: 2/23/2024 11: 09 am

						2/23/2024 11:	09 am
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Coot Contor Deceriation	Dool o /Codo	Amount	Cost Conton	line #	Wko+ A 7	
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
26. 00	Depreciation - NEW CAP REL	1.00		NEW CAP REL COSTS-BLDG &	1. 00	0.00	26. 00
20.00	COSTS-BLDG & FIXT		0	FIXT	1.00	0	20.00
26. 01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-ALU BLDG	1. 01	0	26. 01
20.01	COSTS-ALU BLDG		0	NEW CAL REE COSTS-ALO BEDG	1.01	0	20.01
26. 02	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-2007	1. 02	0	26. 02
20.02	COSTS-2007 HOSPITAL			HOSPI TAL	1.02	Ĭ	20.02
26. 03	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-2007 MOB	1. 03	0	26. 03
	COSTS-2007 MOB		_			_	
27.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
27. 01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
	COSTS-MVBLE EQUIP NEW HO			EQUIP NEW HO			
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29.00	Physicians' assistant		0		0. 00	0	29. 00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
20.00	limitation (chapter 14)		40.4	NEW OAR REL COCTO MARIE	0.01		00.00
32. 00	CAH HIT Adjustment for	А	-424	NEW CAP REL COSTS-MVBLE	2. 01	9	32.00
22.00	Depreciation and Interest	D	10.050	EQUIP NEW HO	7.01	_	22.00
33.00	NURSING HOME RENTAL INCOME	В	-12, 350	OPERATION OF PLANT-SCC	7. 01	0	
33. 01	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 01
33. 05	(3) PROVI DER RHC REVENUE	В	-12 634	RURAL HEALTH CLINIC	88. 00	0	33. 05
33. 06	PART B BILLING COSTS	A		HOSPITAL BILLING	5. 03	0	
33. 07	SCHOOL ATHLETIC TRAINING	В		PHYSI CAL THERAPY	66. 00	0	1
33.07	REVENUE	В	40, 550	THISTORE THERATT	00.00		33.07
33. 08	HOSPITAL BED ASSESS (UP TO	Α	-371, 601	OTHER ADMINISTRATIVE AND	5. 04	0	33. 08
	PAID AMT)		,	GENERAL		_	
33. 09	MARKETING EXPENSES - NONALLOW	Α	-80, 332	OTHER ADMINISTRATIVE AND	5. 04	0	33. 09
			·	GENERAL			
34.00	LOBBYING EXPENSE ON DUES PAID	Α	-30, 090	OTHER ADMINISTRATIVE AND	5. 04	0	34.00
				GENERAL			
35.00	COMMMUNITY GRANTS / DONATIONS	Α	-3, 542	OTHER ADMINISTRATIVE AND	5. 04	0	35. 00
	/ PROM			GENERAL			
36.00	NH BED ASSESSMENT	Α	· ·	OTHER LONG TERM CARE	46. 00	0	
	AR INSURANCE REVENUE	В		OTHER LONG TERM CARE	46. 00	0	
	MISC CLINIC REVENUE	В		RURAL HEALTH CLINIC II	88. 01	0	1
40. 00	SENIOR CARE CAMPUS CAFETERIA	В		DI ETARY-SCC	10. 01	0	
41. 00	OFFSET INTERNAL ALLOCATION FOR	В	-86, 237	DI ETARY-SCC	10. 01	0	41. 00
	ADC/A			BUBAL UEAL TU OLIANI O			
42.00	RHC PROVIDER OR TIME	А	-29, 622	RURAL HEALTH CLINIC	88. 00	0	
43. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	43.00
42 04	(3)	Α.	074 074	DDIES CHARCED TO DATIENTS	70.00	_	42 01
43. 01	PHARMACY CONTRACT PROG EXPENSE			DRUGS CHARGED TO PATIENTS	73.00	0	
43. 02	SLEEP MISC REVENUE	В		OPERATION OF PLANT	7. 00	0	
43. 03	LAPSE CY PORT OF ADV REFUND	А	24,070	NEW CAP REL COSTS-2007	1. 02	11	43. 03
43. 04	2006 NH MISC REVENUE	В	2 500	HOSPITAL OTHER LONG TERM CARE	46. 00	0	43. 04
50.00	TOTAL (sum of lines 1 thru 49)		-2, 509 -4, 759, 871		40.00		50.00
50.00	(Transfer to Worksheet A,		-4, /37, 6/1				30.00
	column 6, line 200.)						
(1) Do	scription - all chapter referen	ooo in this oo	luma nostola t	o CMC Dub 1E 1		1	

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 14-1302

Period: Worksheet A-8-2 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am

							2/23/2024 11	:09 am_
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	,
		I denti fi er	Remuneration	Component	Component		ider Component	
		i dontin i o	Tromarior a tron	J Compositorit	ooporrorre		Hours	
	1. 00	2.00	3. 00	4 00	5. 00	6. 00	7. 00	
1.00				4.00				1.00
1. 00		EMERGENCY	1, 804, 110					1
2.00		LABORATORY	12, 083		.2,000	[ C	0	
3.00	54.00	RADI OLOGY-DI AGNOSTI C	570, 338	570, 338	3 0	(	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	17, 537	17, 537	7	l		4.00
5.00	50.00	OPERATING ROOM	143, 693	143, 693	3	1 (	ol a	5.00
6. 00		CLINIC	1, 184, 311			7		6.00
7. 00	0.00		1, 104, 311	1, 104, 311				1
			0	`	1		1	
8. 00	0.00		0		0		0	
9.00	0.00		0	(	0	[ C	0	9.00
10.00	0.00		0	(	0	[ C	0	10.00
200.00			3, 732, 072	2, 456, 932	1, 275, 140		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er			Memberships &	Component	of Mal practice	
		T deliter i i ei		Li mi t	Continuing	Share of col.	Insurance	
				Limit	Education	12	Trisul ance	
	1.00	2.00	0.00	0.00			14.00	
	1.00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		EMERGENCY	0	(	1	1	1	
2. 00		LABORATORY	0	(	1	[ C	0	
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	(	0	[ C	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	(	0	l c	0	4.00
5.00	50.00	OPERATING ROOM	0		0	1	ol o	5.00
6. 00		CLINIC	0			-		1
7. 00	0.00							1
			0				1	1
8. 00	0. 00		0		) 0		0	0.00
9. 00	0.00		0	(	· · · · · · · · · · · · · · · · · · ·	[ C	0	
10.00	0.00		0	(	0	[ C	0	10.00
200.00			0	(	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	+	
1 00		EMERGENCY	15.00	16.00				1.00
1.00						1 011,000	1	1
2. 00		LABORATORY	0			C	1	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	(	1	570, 338		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	(	0	17, 537	7	4.00
5.00	50.00	OPERATING ROOM	0		0	143, 693	3	5.00
6. 00		CLINIC	0		0	1, 184, 311		6.00
7. 00	0.00		١		· · · · · · · · · · · · · · · · · · ·	1, .5.,611		7. 00
8. 00	0.00						3	8.00
			ا	1	1			1
9. 00	0. 00		0	1		1	4	9. 00
10.00	0.00		0	(		1	Ŋ	10.00
200.00			0	(	0	2, 456, 932	2	200.00

ע וכוטנ	ABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provider CCN: 14-1302	Peri od: From 10/01/2022	Worksheet A-8- Parts I-VI	-3	
	E SUPPLI ERS			To 09/30/2023			
				Occupati onal Therapy	Cost	<u> </u>	
					1.00		
	PART I - GENERAL INFORMATION				1. 00		
. 00	Total number of weeks worked (excluding aide	s) (see instruct	i ons)		10	1.0	
. 00 . 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi	sor or theranist	was on provider site (	saa instructions)	150 22	2. 0 3. 0	
. 00	Number of unduplicated days in which therapy				0	4. (	
	nor therapist was on provider site (see inst			`			
. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther			,	0	5. ( 6. (	
. 00	assistant and on which supervisor and/or the					0. (	
. 00	instructions)				6. 47	7. (	
. 00 . 00	Standard travel expense rate Optional travel expense rate per mile				0.47	8. (	
		Supervi sors	Therapists Assistant		Trai nees		
0. 00	Total hours worked	1. 00	2. 00 3. 00 148. 75 0	4. 00 0. 00	5. 00	9. (	
10.00	AHSEA (see instructions)	0.00		0.00		10.0	
11.00	Standard travel allowance (columns 1 and 2,	45. 61	45. 61	0. 00		11.0	
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	•	0	43	0		12. C	
12. 01	Number of travel hours (offsite)	0	0 0	0		12. C	
3. 00	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	0		13.0	
					1. 00		
	Part II - SALARY EQUIVALENCY COMPUTATION				1.00		
	Supervisors (column 1, line 9 times column 1				0		
5. 00 6. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,		13, 567 0	15. ( 16. (			
7. 00	Subtotal allowance amount (sum of lines 14 a	13, 567	17. (				
8. 00	others)						
9. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l	0	18. ( 19. (				
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory t				20.0	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	amount from line 20. Otherwise complete line	es 21-23.					
1. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			ns 1 and 2, line 9	91. 21	21.0	
22. 00	Weighted allowance excluding aides and train				13, 682	22.0	
3.00	Total salary equivalency (see instructions)				13, 682	23.0	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	NANCE AND TRAVEL	EXPENSE COMPUTATION -	PROVIDER SITE			
	Therapists (line 3 times column 2, line 11)				1, 003		
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all others)		0 1, 003	25. C	
7. 00	Standard travel expense (line 7 times line 3	s 3 and 4 for all	1, 003	27. (			
	others)			6.11			
8. 00	Total standard travel allowance and standard 27)	travei expense	at the provider site (s	um of lines 26 and	1, 145	28.0	
	Optional Travel Allowance and Optional Travel		2 11 12)		0.000		
9. 00 0. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		2, line 12 )		3, 922 0	29. 0 30. 0	
1.00	Subtotal (line 29 for respiratory therapy or		3, 922	31.0			
2.00	Optional travel expense (line 8 times column	s 1 and 2, line	13 for respiratory ther	apy or sum of	0	32.0	
	columns 1-3, line 13 for all others)  Standard travel allowance and standard trave	l expense (line	28)		1, 145	33.0	
3. 00			flines 27 and 31)		0	34.0	
4. 00	Optional travel allowance and standard trave	, ,			01	35.0	
4. 00	Optional travel allowance and optional trave	l expense (sum o		EDVICES OUTSIDE DE			
4. 00	1 .	l expense (sum o		ERVICES OUTSIDE PR			
4. 00 5. 00 6. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11)	l expense (sum o		ERVICES OUTSIDE PR	OVI DER SITE 0	36.0	
6. 00 7. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	l expense (sum o		ERVICES OUTSIDE PR	OVIDER SITE  O O	37.0	
4. 00 5. 00 6. 00 7. 00 8. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	I expense (sum o ANCE AND TRAVEL	EXPENSE COMPUTATION - S	ERVICES OUTSIDE PR	OVI DER SITE 0		
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW, Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	I expense (sum of lines 5 and Expense	EXPENSE COMPUTATION - S	ERVICES OUTSIDE PF	OVIDER SITE  0 0 0 0	37. ( 38. ( 39. (	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.	M of lines 5 and Expense  1 Expense  1 Expense  1 Limes column	EXPENSE COMPUTATION - S	ERVICES OUTSIDE PF	OVIDER SITE  0 0 0 0	37. ( 38. ( 39. ( 40. (	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times columns)	M of lines 5 and Expense  1 Expense  1 Expense  1 Limes column	EXPENSE COMPUTATION - S	ERVICES OUTSIDE PF	OVIDER SITE  0 0 0 0	37. ( 38. ( 39. (	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times columns)	m of lines 5 and Expense O1 times column Taylor Times column Times column Times column Times column Times column Times column	6) 2, line 10) , line 13.01)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37. ( 38. ( 39. ( 40. ( 41. (	

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	MI DWEST MEDI FURNI SHED BY	Provi der Co		Period: From 10/01/2022 To 09/30/2023	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 2/23/2024 11:	-3 pared:
					Occupati onal Therapy	Cost	
						1. 00	
	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 au Assistants	nd 43 - see i Aides	nstructions) Trainees	0 Total	46.00
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION  Overtime hours worked during reporting period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47. 00
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						
	Overtime rate (see instructions)	0.00	0.00	•			48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00				49.00
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	O. C	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	91, 21	0.00	0.0	0 00		
53. 00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	91.21	0.00		0.00		52. 00 53. 00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	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		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	0	0		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 25\\			13, 682 1, 145	
59. 00	Travel allowance and expense - Offsite service			6)		0	
	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions) Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					14, 827	
	Total cost of outside supplier services (from					13, 039	1
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - if negative	e, enter zero)			0	65.00
	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		1, 003	100. 00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or su	um of lines 3 a	and 4 for all	others		100. 01 100. 02
	Line 27 = line 7 times line 3 for respiratory				others	142	101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	29 and 30 for a	all others			101. 01 101. 02
101.02							
102. 00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line	·	102. 00 102. 01

| Peri od: | Worksheet B | From 10/01/2022 | Part | | To | 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1302

Cost Center Description						To	09/30/2023	Date/Time Prep 2/23/2024 11:	
A   C   C   C   C   C   C   C   C   C						CAPI TAL REL	ATED COSTS	2/23/2024 11.	O7 alli
A		Cost Contor Doscription		Not Evpopeds	NEW DIDC 8.	NEW ALLI PLDC	NEW 2007	NEW 2007 MOR	
		cost center bescription				NEW ALO DEDO		NEW 2007 WOD	
Coll 77									
DEBERAL SERVICE ODST_CENTERS									
1.00					1.00	1. 01	1. 02	1. 03	
1.01   00101   NEW CAP REL COSTS-ALU BLDO   52,816   0   52,816   0   2,347,888   1.02   1.02   1.00   1.	4 00		FLVT	5 200	F 200				4 00
1.0.0   00102   MIN CAP MIT CONTST-2007   MISS   1.0   0   0   0   0   0   0   0   0   0		1		· .					
2 00 00200 New Cap Ret COSTS -MURIE COULP NEW HO	1. 02	00102 NEW CAP REL COSTS-2007 HO	OSPI TAL		0		2, 347, 888		1. 02
2.01   0.0001   NEW CAP PREL COSTS-WARLE COULT PIEUR HO   1.011, 964   0.0001   0.00070   0.0007				11 004	0	0	0	0	
4.00   0.0400   DIPLOYEE BENEFITS DEPARTMENT   3.597,764   0   0   3.994   0   5.01				· .					
5.02   0.0550   INFORMATION TECHNIQLODY   225,034   61   0   16,855   0   5.02   0.05	4.00	00400 EMPLOYEE BENEFITS DEPARTM		3, 597, 764	-		0	-	4.00
5.03 (0.0590) MOSPITAL BILLING (0.907) ALTO CONTROL					-	· -			
0.00 0 0000 [MIAINTENINGE & REPAIRS 0 0 0 0 1 157, 927 07.00 7.00 0070 0 0 PERATION OF PLANT 757, 000 0 0 157, 927 07.00 7.00 0 0 0 157, 927 07.00 7.00 0 0 0 157, 927 07.00 7.00 0 0 0 0 7.01 157, 927 07.00 0 0 0 0 7.01 157, 927 07.00 0 0 0 0 157, 929 0 8.00 0 8.01 0 0 0 0 15, 959 0 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							10, 833		
7.00   0.070   DERAITON OF PLANT   757,000   0   157,927   7,00   7.00			GENERAL	1, 914, 687			203, 652		
7. 01 0.0701 (DPERATION OF PLANT-SCC 30.1, 76.6		1		757 000			0 157 927		
8.01   0.0801   LAUNDRY & LINEN SERVICE-SCC   32, 813   21   0   0   0   8.01     9.01   0.0900   0.008EKEPI NG-SCC   114, 685   39   0   0   0   0   0     9.01   0.0900   DIEJARY   18, 1134   0   0   142, 177   0   10.00     10.01   10.00   10.000   DIEJARY   18, 1134   0   0   0   142, 177   0   10.00     10.01   10.00   10.000   DIEJARY   18, 1134   0   0   0   0   0   10.01     10.01   10.00   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   10.00     10.01   DIEJARY-SCC   586, 676   152   0   0   0   0   0   11.00     11.01   0.01   10.00   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   11.00     11.01   0.01   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   11.00     11.01   0.01   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.01   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.01   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.01   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0   0     10.000   10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0   0   0     10.000   DIEJARY   18, 1134   0   0   0   0   0   0   0   0   0							137, 727		
9.00   00000   MUSEKEEP ING SCO						0	15, 959		
9.01 00901   HOUSEKEEPING-SCC		1	SCC			0	0 12 103	-	
10.00   10.001   DIETARY-SCC							12, 103		
11.00   01100 CAFETERIA - SCC							143, 717		
11. 01   01101   CAFETERIA - SCC				588, 676			0	-	
14. 00   01400   CENTRAL SERVICE & SUPPLY   132, 291   0   0   30, 572   0   14. 00   16. 00   10600   MEDICAL RECORDS & LI BRARY   271, 345   0   0   30, 797   0   16. 00   19. 00   1900   1900   000   000   0   0   0   0   0   0				o			0		
15.00   01500   PHARMACY				· .			· ·		
16. 00   01600   MEDICAL RECORDS & LIBRARY   271, 345   0   0   30, 797   0   16. 00   19. 00   19. 00   19. 00   19. 00   0   0   0   0   0   0   0   0   0					-				
INPATE ENT ROUTINE SERVICE COST CENTERS   1, 359, 743   0   0   396, 724   0   3   0.0   0   0   0   0   0   0   0   0		1	<b>Y</b>	-	-			-	
0.00   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	19. 00			571, 093	0	0	0	0	19. 00
42.00   04200   SUBERDVI DER   0   0   0   0   0   0   44.00	30. 00		CENTERS	1, 359, 743	0	0	396, 724	0	30. 00
AGE   00   04600   OTHER LONG TERN CARE   2, 254, 654   1, 857   0   0   0   0   0   0   0   0   0	42.00	04200 SUBPROVI DER		0	0	0	0		42.00
ANCILLARY SERVICE COST CENTERS   917, 469									
53.00   05300   ANESTHESI OLOGY   0   0   2, 421   0   53.00	40.00			2, 254, 054	1, 657	0	<u> </u>	0	40.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   1,041,817   0   0   162,769   0   54.00   57.00   05700   CT SCAN   0   0   0   0   0   0   0   0   0				917, 469			· ·		
57.00   05700   CT SCAN   0   0   0   0   0   0   0   57.00		1 1		0 1 041 817	0				
60.00				0	0	Ö			
64.00   06400   INTRAVENOUS THERAPY   38,048   0   0   0   0   64.00   65.00   06500   RESPIRATORY THERAPY   57,296   0   0   8,428   0   65.00   66.01   06600   PHYSI CAL THERAPY   1,678,820   0   0   193,879   0   66.00   66.01   06601   CARDI AC REHAB   144,277   0   0   13,448   0   66.01   67.00   06700   OCCUPATI ONAL THERAPY   159,127   0   0   16,676   0   67.00   68.00   06800   SPEECH PATHOLOGY   99,423   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1,079,335   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   797,332   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   797,332   0   0   0   0   0   76.01   03930   SHEEP LAB   0   0   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.01   08801   RURAL HEALTH CLINIC   1   673,231   0   0   0   248,389   0   79.00   09000   CLINIC   573,991   0   0   248,389   0   79.00   09000   CLINIC   573,991   0   0   248,389   0   79.00   09000   CLINIC   573,991   0   0   0   248,389   0   79.00   09000   CLINIC   574,331   0   0   0   0   70.00   09000   CLINIC   574,391   0   0   0   0   70.00   09000   CLINIC   574,391   0   0   0   0   70.00   09000   06000   06000   06000   06000   70.00   09000   06000   06000   06000   70.00   09000   06000   06000   06000   70.00   09000   06000   06000   70.00   09000   060000   060000   70.00   09000   060000   060000   70.00   09000   06000000   70.00   09000   060000000000000000000000000		1	NG (MRI)	0	0	0	0		
65.00   06500   RESPIRATORY THERAPY   1,678,820   0   0   8,428   0   65.00   66.00   06600   PHYSI CAL THERAPY   1,678,820   0   0   193,879   0   66.00   66.01   06601   CARDIJAC REHAB   144,277   0   0   13,448   0   66.01   67.00   06700   OCCUPATI ONAL THERAPY   159,127   0   0   16,676   0   67.00   68.00   06800   SPECEP PATHOLOGY   99,423   0   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   99,423   0   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   99,423   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,079,335   0   0   0   0   0   0   72.00   072.00   IMPL. DEV. CHARGED TO PATIENTS   1,079,335   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   797,332   0   0   0   0   0   0   76.00   03020   SLEEP LAB   0   0   0   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   0   76.02   OUTPATIENT SERVICE COST CENTERS    88.00   08800   RURAL HEALTH CLINIC   1   673,231   0   0   0   256,996   0   88.01   08801   RURAL HEALTH CLINIC   573,991   0   0   248,389   0   91.00   90.00   90000   CLINIC   ST3,991   0   0   248,389   0   91.00   91.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1,971,245   0   0   248,389   0   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   248,389   0   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   113.00   113.00   113.00   117ERST   SUBJOCAL					0	0	48, 234 0	-	
66.01   06601   CARDI AC REHAB   144, 277   0   0   13, 448   0   66.01   67.00   06700   OCCUPATI ONAL THERAPY   159, 127   0   0   16,676   0   67.00   68.00   06800   SPEECH PATHOLOGY   99, 423   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,079, 335   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   79, 335   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   797, 332   0   0   0   0   0   76.00   03020   SLEEP LAB   0   0   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   76.02   03530   SNF PHYSICAL THERAPY - SCC THERAPY   0   0   0   0   0   88.01   03800   RURAL HEALTH CLINIC   1,997,857   0   0   256,996   0   88.01   03800   RURAL HEALTH CLINIC   1,997,857   0   0   256,996   0   88.01   08800   RURAL HEALTH CLINIC   573,991   0   0   44,828   0   90.00   91.00   09100   EMERGENCY   1,971,245   0   0   248,389   0   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   92.00   93.00   04040   FAMIL LY PRACTICE   0   0   0   0   0   0   118.00   SDETIALS (SUM OF LINES )   113.00   118.00   SUBTOTALS (SUM OF LINES )   118.00   119.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   192.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   192.01   19000   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   192.01   19000		06500 RESPIRATORY THERAPY		57, 296	0	0	8, 428		
67. 00   06700   0CCUPATIONAL THERAPY   159, 127   0   0   16,676   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   99, 423   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,079, 335   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   797, 332   0   0   0   0   0   76. 00   03320   SLEEP LAB   0   0   0   0   0   0   76. 01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   76. 02   03530   SNF PHYSICAL THERAPY - SCC THERAPY   0   0   0   0   0   76. 02   03530   SNF PHYSICAL THERAPY - SCC THERAPY   0   0   0   0   88. 01   08800   RURAL HEALTH CLINIC   1   673, 231   0   0   256, 996   0   88. 01   08800   RURAL HEALTH CLINIC   1   673, 231   0   0   248, 389   0   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   93. 00   04040   FAMILY PRACTICE   0   0   0   0   0   118. 00   SPECLAL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   113. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   30, 584, 451   3, 476   15, 879   2, 320, 050   0   119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   192. 01   19200   PHYSICIANS' PRIVATE OFFICES   0   0   0   0   0   192. 00   19200   OTHER NONREI MBURSABLE   0   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTH					0	0			
68. 00   06800   SPEECH PATHOLOGY   99, 423   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1,079, 335   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   797, 332   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   797, 332   0   0   0   0   0   76. 00   03020   SLEEP LAB   0   0   0   0   0   76. 01   03950   PAIN CLINIC / SERVICE   0   0   0   0   0   76. 01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76. 02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   0   88. 00   08800   RURAL HEALTH CLINIC   1   673, 231   0   0   256, 996   0   88. 01   08801   RURAL HEALTH CLINIC   1   673, 231   0   0   0   44, 828   0   90. 00   09000   CLINIC   573, 991   0   0   44, 828   0   90. 00   91. 00   09100   DEBERGENCY   1, 971, 245   0   0   248, 389   0   91. 00   09200   DESERVATI ON BEDS (NON-DISTINCT PART)   92. 00   92. 00   09200   DESERVATI ON BEDS (NON-DISTINCT PART)   92. 00   93. 00   SPECIAL PURPOSE COST CENTERS   113. 00   118. 00   SPECIAL PURPOSE COST CENTERS   113. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   30, 584, 451   3, 476   15, 879   2, 320, 050   0   119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   192. 01   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192. 01   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   192. 01   19200   MINDEST MEDI CAL CLINIC   0   0   0   0   192. 01   19200   OTHER NONREI MBURSABLE   0   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   194. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTHER NONREI MBURSABLE   0   0   0   0   195. 00   07950   OTHER NONREI MBURSABLE   0									
71. 00	68.00	06800 SPEECH PATHOLOGY			0	0	0		68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   797, 332   0   0   0   0   0   0   73. 00   76. 00   0   0   0   0   0   0   0   0   0		1	TO DATIENTS	1 070 225	0	0	0		
73. 00				1,074,333	0	0	0		
76. 01 03950 PAIN CLINIC / SERVICE 0 0 0 0 0 0 0 76. 01 76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY 0 0 0 0 0 0 0 76. 02  OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 1 1,997,857 0 0 0 256,996 0 88. 00  88. 01 08801 RURAL HEALTH CLINIC 1 1 673,231 0 0 0 0 88. 01  90. 00 09000 CLINIC 573,991 0 0 44,828 0 90. 00  91. 00 09100 EMERGENCY 1,971,245 0 0 0 248,389 0 91. 00  92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00  93. 00 04040 FAMILY PRACTICE 0 0 0 0 0 0 0 93. 00  113. 00 11300 INTEREST EXPENSE 113. 00  113. 00 11300 INTEREST EXPENSE 113. 00  NONRE! MBURSABLE COST CENTERS  190. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 13,314 0 190. 00  192. 01 19201 MIDWEST MEDICAL CLINIC 0 0 0 0 0 0 192. 01  194. 00 07950 OTHER NONRE! MBURSABLE		07300 DRUGS CHARGED TO PATIENTS		797, 332	0	0	0		
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY 0 0 0 0 0 0 0 0 76. 02 0 0 0 0 0 0 0 0 76. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0		
Section   Service Cost Centers   Service C			CC THERAPY	o			0		
88. 01	00.00	OUTPATIENT SERVICE COST CENTER		4 007 057			25/ 22/		00.00
90. 00					0	0	256, 996 0		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   0   0   0   0   0   0   93. 00   93.		09000 CLI NI C			0	0	44, 828		90.00
93. 00   04040   FAMILY PRACTICE   0   0   0   0   0   93. 00			CTINCT DADT)	1, 971, 245	0	0	248, 389	0	
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   SUBTOTALS (SUM OF LINES 1 through 117)   30,584,451   3,476   15,879   2,320,050   0   118.00   NONREI MBURSABLE COST CENTERS			DIINGI PAKI)	0	0	0	0	0	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 30, 584, 451 3, 476 15, 879 2, 320, 050 0 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 13, 314 0 190. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00  192. 01 19201 MI DWEST MEDI CAL CLINI C 0 0 0 0 0 192. 01  194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 0 0 194. 00		SPECIAL PURPOSE COST CENTERS							
NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   13,314   0   190.00   192.00   19200   19200   19200   19200   19200   19200   19200   19200   19201   19			1 through 117\	30 504 451	2 174	15 Q70	3 330 UEU		
190. 00     19000 GFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     13, 314     0     190. 00       192. 00     19200 PHYSI CLANS' PRI VATE OFFICES     0     0     0     0     0     192. 00       192. 01     19201 MI DWEST MEDI CAL CLINIC     0     0     0     0     0     192. 01       194. 00     07950 OTHER NONREI MBURSABLE     0     0     0     0     0     194. 00	110.00		i tili ougii 117)	30, 304, 431	3, 4/0	10,079	2, 320, 030	U	110.00
192. 01   19201   MI DWEST   MEDI CAL   CLI NI C   0   0   0   0   192. 01   194. 00   07950   OTHER   NONREI   MBURSABLE   0   0   0   0   194. 00		0 19000 GIFT, FLOWER, COFFEE SHOP		0	0	0	13, 314		
194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 0 0 194. 00			JES	0	0	0	0		
194. 01 07951 ASSI STED LI VI NG UNI TS   447, 872  0  34, 171  0  0 194. 01				o	0	0	0	0	194. 00
	194. 01	1 07951 ASSISTED LIVING UNITS		447, 872	0	34, 171	0	0	194. 01

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der	om 10/01/2022 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

					2/23/2024 11:	<u>09 am</u>
			CAPI TAL REL	ATED COSTS		
Cost Center Description	Net Expenses	NEW BLDG &	NEW ALU BLDG	NEW 2007	NEW 2007 MOB	
	for Cost	FLXT		HOSPI TAL		
	Allocation					
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	1. 02	1. 03	
194. 02 07952 ADULT DAY CARE	0	0	2, 766	0	0	194. 02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194. 03
194. 04 07954 I DLE SPACE	0	1, 923	0	0	0	194. 04
194. 05 07955 COMMUNITY FITNESS CENTER	13, 080	0	0	14, 524	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 through 201)	31, 045, 403	5, 399	52, 816	2, 347, 888	0	202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part I | Date/Time Prepared: | 2/23/2024 | 11:09 am | Provider CCN: 14-1302

						2/23/2024 11:	09 am
		CAPI TAL REI	LATED COSTS				
	Cost Conton Decemintion	NEW MYDLE	NEW MYDLE	EMDLOVEE	ADMITTING	I NFORMATI ON	
	Cost Center Description	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO	EMPLOYEE BENEFITS	ADMITTI NG	TECHNOLOGY	
		LQUIT	LQUIT NEW 110	DEPARTMENT		TECHNOLOGI	
		2. 00	2. 01	4. 00	5. 01	5. 02	
	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 00200 NEW CAP REL COSTS-MVBLE EQUIP	11 007					1.03
2. 00 2. 01	00200 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	11, 886 0					2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	3, 597, 764			4.00
5. 01	00570 ADMITTING	0	0	139, 397	672, 124		5. 01
5.02	00550 I NFORMATI ON TECHNOLOGY	0	75, 330	98, 256	0	1, 015, 536	5. 02
5. 03	00590 HOSPI TAL BILLING	0	0	0	0	0	5. 03
5. 04	00540 OTHER ADMINISTRATIVE AND GENERAL	1, 004	115, 824	238, 342	0	150, 447	5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT-SCC	0 301	34, 880 0	44, 212 28, 091	0	28, 209 0	7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0	· -	20, 091	0	0	8.00
8. 01	00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8. 01
9. 00	00900 HOUSEKEEPI NG	Ö	294	67, 933	0	0	9.00
9. 01	00901 HOUSEKEEPI NG-SCC	0	0	26, 374	0	0	9. 01
10.00	01000 DI ETARY	0	28, 463	87, 729	0	18, 806	10.00
10. 01	01001 DI ETARY-SCC	0	0	95, 053	0	0	10. 01
11.00	01100 CAFETERI A	0	0	0	0	0	
11. 01 13. 00	01101 CAFETERI A-SCC 01300 NURSI NG ADMI NI STRATI ON	0	0	112, 698	0	4, 702	11. 01 13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY		0	33, 090	0	4, 702	
15. 00	01500 PHARMACY	0	1, 760		0	14, 105	
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö		71, 907	Ö	18, 806	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0		149, 745	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	1	321, 526	65, 582	94, 031	
42.00	04200 SUBPROVI DER	0	0	0	0	0	
44. 00 46. 00	04400 SKILLED NURSING FACILITY 04600 OTHER LONG TERM CARE	0 8, 740		0 534, 788	0	0	
40.00	ANCILLARY SERVICE COST CENTERS	0,740	0	334, 700	<u> </u>	0	40.00
50.00	05000 OPERATING ROOM	0	327, 945	147, 998	107, 927	89, 330	50.00
53.00	05300 ANESTHESI OLOGY	0	20, 149	0	23, 833	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	256, 905	134, 467	133, 174	56, 419	1
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0	-	120, 389	80, 451	0 23, 508	
64.00	06400 I NTRAVENOUS THERAPY	0	21, 251	120, 369	15, 919	23, 508	1
65. 00	06500 RESPI RATORY THERAPY	0	5, 296		1, 127	0	1
66.00	06600 PHYSI CAL THERAPY	0	10, 831	456, 634	74, 976	141, 047	1
66. 01	06601 CARDI AC REHAB	0	8, 545		4, 084	14, 105	
	06700 OCCUPATI ONAL THERAPY	0	0	38, 122	6, 691		67. 00
	06800 SPEECH PATHOLOGY	0	0	25, 862	4, 225	0	
	06900 ELECTROCARDI OLOGY	0	0	0	24 040	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36, 969	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	59, 970	0	73.00
76. 00	03020 SLEEP LAB	Ö	Ö	Ö	0	0	76.00
76. 01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0	1
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	Ι			_1		
88. 00	08800 RURAL HEALTH CLINIC	14	•		0	150, 450	
88. 01 90. 00	08801 RURAL HEALTH CLINIC II 09000 CLINIC	0	.,	63, 150 74, 713	0	51, 717 65, 822	
91.00	09100 EMERGENCY				57, 196	56, 419	
92. 00			21,000	101, 121	07, 170	00, 117	92.00
93. 00		0	0	0	0	0	93.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
118. 00	3 /	10, 059	1, 002, 239	3, 473, 332	672, 124	982, 625	118.00
100.00	NONREI MBURSABLE COST CENTERS		100		ما	0	100 00
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19200 PHYSICIANS' PRIVATE OFFICES	0	102	0	0		190. 00 192. 00
192. U	19200 PHYSICIANS PRIVATE OFFICES		0	0	O O		192.00
	07950 OTHER NONREIMBURSABLE	0		0	ol		194.00
	07951 ASSISTED LIVING UNITS	1, 140	7, 913	120, 927	Ö		194. 01
194. 02	07952 ADULT DAY CARE	687	0	0	0		194. 02
194.03	B 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194. 03

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 14-1302	Period: Worksheet B From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared:

					10 09/30/2023	Date/ITIIIe Pre	
						2/23/2024 11:	09 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW MVBLE	NEW MVBLE	EMPLOYEE	ADMI TTI NG	I NFORMATI ON	
		EQUI P	EQUIP NEW HO	BENEFITS		TECHNOLOGY	
				DEPARTMENT			
		2. 00	2. 01	4. 00	5. 01	5. 02	
194. 04 07954	I DLE SPACE	0	0		0	0	194.04
194. 05 07955	COMMUNITY FITNESS CENTER	0	1, 710	3, 50	5 0	32, 911	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 through 201)	11, 886	1, 011, 964	3, 597, 76	4 672, 124	1, 015, 536	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am

						2/23/2024 11:	
C	Cost Center Description	HOSPI TAL	Subtotal		MAINTENANCE &	OPERATION OF	
		BI LLI NG		ADMINISTRATIV E AND GENERAL	REPAI RS	PLANT	
		5. 03	5A. 03	5. 04	6. 00	7. 00	
GENERAL	L SERVICE COST CENTERS						
	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-ALU BLDG						1.01
	NEW CAP REL COSTS-2007 HOSPITAL NEW CAP REL COSTS-2007 MOB						1.02
	NEW CAP REL COSTS-2007 MOB						1. 03 2. 00
	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.00
	EMPLOYEE BENEFITS DEPARTMENT						4. 00
1 1	ADMITTING						5. 01
5. 02 00550 I	NFORMATION TECHNOLOGY						5. 02
5. 03 00590 H	HOSPITAL BILLING	393, 455					5.03
1 1	OTHER ADMINISTRATIVE AND GENERAL	0	2, 640, 729	2, 640, 729			5.04
	MAINTENANCE & REPAIRS	0	0	0	0	4 405 747	6. 00
1 1	OPERATION OF PLANT	0	1, 022, 228	113, 488	0	1, 135, 716	7.00
1 1	OPERATION OF PLANT-SCC	0	330, 364 104, 645	11 410	0	0 344	7. 01 8. 00
1 1	_AUNDRY & LINEN SERVICE _AUNDRY & LINEN SERVICE-SCC	0	32, 834	11, 618	0	9, 364 0	8. 00
1 1	HOUSEKEEPI NG	0	365, 113	40, 535	Ö	7, 102	9. 00
	HOUSEKEEPI NG-SCC	o	141, 098		ō	0	9. 01
10.00 01000 0	DI ETARY	0	696, 849		О	84, 330	10.00
10. 01   01001	DI ETARY-SCC	0	683, 881	0	0	0	10. 01
	CAFETERI A	0	0	0	0	0	11.00
	CAFETERI A-SCC	0	0	0	0	0	11. 01
	NURSING ADMINISTRATION	0	529, 914	58, 831	0	3, 367	13.00
1 1	CENTRAL SERVICE & SUPPLY PHARMACY	0	195, 953		0	17, 939 20, 333	14. 00 15. 00
	MEDICAL RECORDS & LIBRARY	0	50, 517 392, 977		0	20, 333 18, 071	16.00
	NONPHYSI CI AN ANESTHETI STS	o	720, 838		ol	·	19.00
	ENT ROUTINE SERVICE COST CENTERS	<u> </u>	7207000	00,027	<u> </u>		. , , , ,
30. 00 03000 A	ADULTS & PEDIATRICS	35, 641	2, 327, 337	258, 381	0	232, 789	30.00
	SUBPROVI DER	0	0	0	0	0	42.00
1 1	SKILLED NURSING FACILITY	0	14, 983	0	0	0	44.00
	OTHER LONG TERM CARE	0	2, 800, 039	0	0	0	46. 00
	ARY SERVICE COST CENTERS DEFRATING ROOM	58, 653	1, 890, 674	209, 903	ol	141, 619	50. 00
	ANESTHESI OLOGY	12, 952	59, 355		0	1, 420	53. 00
	RADI OLOGY-DI AGNOSTI C	72, 391	1, 857, 942		Ö	95, 509	54.00
	CT SCAN	0	0	0	Ö	0	57. 00
58.00 05800 N	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60. 00 06000 L	_ABORATORY	43, 722	1, 436, 376		0	28, 303	60.00
1 1	NTRAVENOUS THERAPY	8, 651	62, 618		0	0	64.00
1 1	RESPI RATORY THERAPY	612	72, 759		0	4, 945	65.00
	PHYSI CAL THERAPY CARDI AC REHAB	40, 746	2, 596, 933		0	122, 970	66. 00 66. 01
	OCCUPATIONAL THERAPY	2, 219 3, 636	224, 838 228, 954	24, 962 25, 418	0	7, 891 9, 785	67.00
	SPEECH PATHOLOGY	2, 296	131, 806		0	9, 765	68.00
	ELECTROCARDI OLOGY	0	0		o	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 091	1, 136, 395	126, 163	o	0	71. 00
	MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	DRUGS CHARGED TO PATIENTS	32, 591	889, 893	98, 796	0	0	73.00
	SLEEP LAB	0	0	0	0	0	76.00
	PAIN CLINIC / SERVICE SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76. 01
	IENT SERVICE COST CENTERS	U_	0	l O	υ	0	76. 02
	RURAL HEALTH CLINIC	20, 129	2, 604, 187	289, 123	n	150, 799	88. 00
	RURAL HEALTH CLINIC II	6, 174	795, 793		ő	0	88. 01
90.00 09000 0		1, 868	769, 678		o	17, 097	90.00
91. 00 09100 E	EMERGENCY	31, 083	2, 540, 358	282, 031	0	145, 749	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
	FAMILY PRACTICE	0	0	0	0	0	93. 00
	L PURPOSE COST CENTERS						110.00
	NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	393, 455	30, 348, 858	2 421 720	o	1, 119, 382	113.00
	MBURSABLE COST CENTERS	393, 400	30, 340, 636	2, 631, 730	<u> </u>	1, 119, 302	116.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	13, 416	1, 489	0	7 812	190. 00
	PHYSICIANS' PRIVATE OFFICES	O	13, 410	0	Ö		192.00
	MIDWEST MEDICAL CLINIC	ol	0	l o	ol		192. 01
	OTHER NONREI MBURSABLE	0	0	0	o		194. 00
	ASSISTED LIVING UNITS	О	612, 023		o		194. 01
	ADULT DAY CARE	0	3, 453	0	O		194. 02
	GRANT FUNDED PROGRAMS	0	0	0	0		194. 03
194. 04 07954 I	DLE SPACE COMMUNITY FITNESS CENTER	0	1, 923		0		194. 04 194. 05
174.00 07905 0	SOUNDINI II IIINESS CENIER	U	65, 730	1,291	υĮ	0, 322	174. 00

Health Fin	ancial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der CO		eri od:	Worksheet B	
					rom 10/01/2022 o 09/30/2023		anarad.
				'	0 09/30/2023	Date/Time Pro	
	Cost Center Description	HOSPI TAL	Subtotal	OTHER	MAINTENANCE &	OPERATION OF	
		BILLING		ADMI NI STRATI V	REPAI RS	PLANT	
				E AND GENERAL			
		5. 03	5A. 03	5. 04	6. 00	7. 00	
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	C	0	(	201.00
202. 00	TOTAL (sum lines 118 through 201)	393, 455	31, 045, 403	2, 640, 729	0	1, 135, 716	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am

	005047101105	LAUNDRY		0 09/30/2023	2/23/2024 11:	
Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LI NEN	HOUSEKEEPI NG	HOUSEKEEPI NG- SCC	
	7. 01	8. 00	SERVI CE-SCC 8. 01	9. 00	9. 01	
GENERAL SERVICE COST CENTERS	7.0.	0, 00	0.01	71.00	71 01	
1.00 O0100 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 2. 00   00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 03 2. 00
2. 01   00200  NEW CAP REL COSTS-MVBLE EQUIP  2. 01   00201   NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01   00570  ADMI TTI NG						5. 01
5. 02 00550 I NFORMATION TECHNOLOGY						5. 02
5. 03   00590   HOSPI TAL   BI LLI NG						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	330, 364	405 (07				7. 01
8. 00   00800   LAUNDRY & LINEN SERVICE	1 043	125, 627	22.07/			8.00
8. 01   00801   LAUNDRY & LI NEN SERVI CE-SCC 9. 00   00900   HOUSEKEEPI NG	1, 042	0	33, 876			8. 01
9. 00   00900  HOUSEKEEPI NG 9. 01   00901  HOUSEKEEPI NG-SCC	1, 981	0	0	412, 750	143, 079	9. 00 9. 01
10. 00   01000 DI ETARY	1, 701	0	0	34, 070	143,079	10.00
10. 01 01001 DI ETARY-SCC	7, 699	0	0	0,070	4, 889	10.00
11. 00 01100 CAFETERI A	0	Ö	Ö	0	0	11.00
11. 01   01101   CAFETERI A-SCC	0	0	0	0	0	11.01
13.00 01300 NURSING ADMINISTRATION	3, 452	0	0	1, 360	2, 192	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	0	0	7, 248	0	14.00
15. 00   01500   PHARMACY	0	0	0	8, 215	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	.,	0	16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS		105 (07		04.047	0	20.00
30. 00   03000   ADULTS & PEDI ATRI CS 42. 00   04200   SUBPROVI DER	0	125, 627 0	0	94, 047	0	30. 00 42. 00
44. 00 04400 SKILLED NURSING FACILITY	9, 036	0	0	0	5, 737	44.00
46.00 04600 OTHER LONG TERM CARE	94, 005	0	33, 876	_	59, 686	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	0	57, 215	0	50.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	574	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	38, 586	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
60. 00   06000   LABORATORY	0	0	0	11, 435	0	60.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	0	0	0	1, 998	0	64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	0	18, 108	0	66.00
66. 01   06601 CARDI AC REHAB	0	0	0	1, 860	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 435	Ő	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	Ö	0	Ō	68. 00
69. 00 06900 ELECTROCARDI OLOGY	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
0UTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C	0	0	0	62, 784	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	0	0	0	02, 784	0	88. 01
90. 00   09000   CLI NI C	0	0	0	6, 376	0	90.00
91. 00   09100   EMERGENCY	0	Ö	Ö	58, 884	ő	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	117, 215	125, 627	33, 876	411, 496	72, 504	118. 00
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200  PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201  MI DWEST MEDI CAL CLINI C		0				192. 00 192. 01
192. 01 19201 MI DWEST MEDICAL CLINIC 194. 00 07950 OTHER NONREI MBURSABLE		0		0		194. 00
194.01 07951 ASSISTED LIVING UNITS	102, 833	) n			65, 291	
194. 02 07952 ADULT DAY CARE	8, 322	n	١			194. 01
194. 03 07953 GRANT FUNDED PROGRAMS	0, 322	Ö	0	Ö		194. 03
194. 04 07954 I DLE SPACE	101, 994	0	Ö	o	0	194. 04
194. 05 07955 COMMUNITY FITNESS CENTER	0	0	<u>                                     </u>	1, 254	0	194. 05

Health Financial S	Systems	MIDWEST MEDICA	L CENTER		In Lie	u of Form CMS-2552-10
COST ALLOCATION -	GENERAL SERVI CE COSTS		Provider C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am
Cost (	Center Description	OPERATION OF	LAUNDRY &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-

						2/23/2024 11:	09 am_
	Cost Center Description	OPERATION OF	LAUNDRY &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-	
		PLANT-SCC	LINEN SERVICE	LINEN		SCC	
				SERVI CE-SCC			
		7. 01	8. 00	8. 01	9. 00	9. 01	
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 through 201)	330, 364	125, 627	33, 876	412, 750	143, 079	202. 00

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Ti me Prepared:

	Cost Center Description	DI ETARY	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	2/23/2024 11: NURSI NG	
	cost center bescription	DI EI/III	D1217411 300	ON ETENIA	ON ETERNIN SOO	ADMI NI STRATI O	
		10. 00	10. 01	11. 00	11. 01	13.00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT					I	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 MYDLE EQUIP						2.00
2. 01 4. 00	OO201   NEW CAP REL COSTS-MVBLE EQUIP NEW HO   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
5. 01	00570 ADMITTING						5. 01
5. 02	00550 I NFORMATION TECHNOLOGY						5. 02
5.03	00590 HOSPITAL BILLING						5. 03
5. 04	00540 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6. 00 7. 00	00600 MAI NTENANCE & REPAI RS						6. 00 7. 00
7. 00 7. 01	OO7OO   OPERATION OF PLANT   OO7O1   OPERATION OF PLANT-SCC						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
8. 01	00801 LAUNDRY & LINEN SERVICE-SCC						8. 01
9. 00	00900 HOUSEKEEPI NG						9. 00
9. 01	00901 HOUSEKEEPI NG-SCC						9. 01
10.00	01000 DI ETARY	892, 613	404 440				10.00
10. 01 11. 00	01001  DI ETARY-SCC  01100  CAFETERI A	0	696, 469 0	0			10. 01 11. 00
11. 00	01101 CAFETERI A-SCC	0	0	0	0		11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	599, 116	
14.00	01400 CENTRAL SERVI CE & SUPPLY	0	0	0	0	0	14.00
	01500 PHARMACY	0	0	0	_	0	
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	_	0	
19.00	01900   NONPHYSICIAN ANESTHETISTS   NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
30. 00	03000 ADULTS & PEDIATRICS	892, 613	0	0	0	334, 079	30.00
42. 00	04200 SUBPROVI DER	0	Ö	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	446, 356	0	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	٥	0	0		120 505	F0 00
50. 00 53. 00	05000   OPERATI NG ROOM   05300   ANESTHESI OLOGY	0	0	0			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	ő	o	0		0	
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
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	0	0	0	0	0	65. 00 66. 00
66. 01	06601 CARDI AC REHAB	0	0	0	0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	o	0	0	0	Ö	67.00
68.00	06800 SPEECH PATHOLOGY	O	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
	03020 SLEEP LAB	0	0	0	0	0	1
	03950 PAIN CLINIC / SERVICE	ő	Ö	0	0	Ö	1
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	O8801   RURAL HEALTH CLINIC II   O9000   CLINIC	0	0	0	0		88. 01 90. 00
	09100 EMERGENCY	0	0	0	0	134, 442	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			, and the second second second second second second second second second second second second second second se		101,112	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	000 (40	444 054			F00 44/	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	892, 613	446, 356	0	0	599, 116	]118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	<u> </u>	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		n	0	0		190.00
	19201 MI DWEST MEDI CAL CLINIC	l ől	ő	Ö	0		192.01
194.00	07950 OTHER NONREI MBURSABLE	o	O	0	0	0	194. 00
	07951 ASSISTED LIVING UNITS	0	250, 113	0	0		194. 01
	07952 ADULT DAY CARE	0	0	0	0		194. 02
	07953 GRANT FUNDED PROGRAMS   07954 IDLE SPACE	0	0	0	0		194. 03 194. 04
	07955 COMMUNITY FITNESS CENTER		0	0	0		194. 04
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u>.                                    </u>	٩				

Health Financial Systems	MIDWEST MEDI	CAL CENTER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B		
				From 10/01/2022			
				To 09/30/2023			
					2/23/2024 11:	<u>09 am</u>	
Cost Center Description	DI ETARY	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	NURSI NG		
					ADMINISTRATIO		
					N		
	10.00	10. 01	11.00	11. 01	13.00		
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	l ol		0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	892, 613	696, 469		0 0	599, 116	202.00	

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

				1	0 07/30/2023	Date/lime Pre   2/23/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	Subtotal	
		SERVI CE &		RECORDS &	ANESTHETI STS		
		SUPPLY 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 1. 03	00102 NEW CAP REL COSTS-2007 HOSPITAL 00103 NEW CAP REL COSTS-2007 MOB						1. 02 1. 03
2. 00	00200 NEW CAP REL COSTS-2007 WOB						2.00
2. 00	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING						5. 01
5. 02	00550 INFORMATION TECHNOLOGY						5. 02
5. 03	00590 HOSPI TAL BILLING						5.03
5. 04 6. 00	OO540 OTHER ADMINISTRATIVE AND GENERAL   OO600 MAINTENANCE & REPAIRS						5. 04 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 HOUSEKEEPI NG						9. 00
9. 01	00901 HOUSEKEEPI NG-SCC						9. 01
10. 00 10. 01	01000  DI ETARY  01001  DI ETARY-SCC						10.00
11. 00	01100 CAFETERI A						10. 01 11. 00
11. 01	01101 CAFETERI A-SCC						11.01
	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVI CE & SUPPLY	242, 895					14.00
15.00	01500 PHARMACY	0	84, 673				15.00
	01600 MEDI CAL RECORDS & LI BRARY	1, 001	0	462, 978	ŀ		16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	800, 865		19. 00
30.00	O3000 ADULTS & PEDIATRICS	8, 188	0	41, 942	ol	4, 315, 003	30.00
42. 00	04200 SUBPROVI DER	0	o	0	o	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	29, 756	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	3, 433, 962	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	20.079	ol	40.022	ol	2 520 107	EO 00
50. 00 53. 00	05300 ANESTHESI OLOGY	29, 078 3, 439	ol Ol	69, 023 15, 242	l .	2, 528, 107 887, 485	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 452	ő	85, 150	000,000	2, 288, 908	54.00
57.00	05700 CT SCAN	0	0	0	o	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0	0	o	0	58. 00
60.00	06000 LABORATORY	0	0	51, 451	0	1, 687, 031	60.00
64. 00	06400 I NTRAVENOUS THERAPY	4, 949	0	10, 181	0	84, 700	64.00
65. 00 66. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	5, 641 9, 960	0	721 47, 949		94, 142 3, 084, 232	65. 00 66. 00
66. 01	06601 CARDI AC REHAB	9, 700	0	2, 612		262, 163	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	679	o	4, 279	o	270, 550	
68.00	06800 SPEECH PATHOLOGY	262	О	2, 702	o	149, 403	68.00
	06900 ELECTROCARDI OLOGY	0	0	0	١		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	140, 387	0	23, 643	0	1, 426, 588	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	04 472	20 252	0	1 111 744	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 SLEEP LAB	49	84, 673	38, 353		1, 111, 764 0	73. 00 76. 00
	03950 PAIN CLINIC / SERVICE	o	Ö	0	l ől	0	1
	03530 SNF PHYSICAL THERAPY - SCC THERAPY	O	ō	0	ō	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	10, 626	0	23, 687	l .	3, 141, 206	
	08801 RURAL HEALTH CLINIC II	3, 332	0	7, 266	l .	894, 740	
	09000   CLI NI C   09100   EMERGENCY	10, 061 9, 791	0	2, 198 36, 579		890, 860 3, 207, 834	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 771	o <sub>l</sub>	30, 377	o o	3, 207, 634	92.00
	04040 FAMILY PRACTICE	0	О	0	o	0	•
	SPECIAL PURPOSE COST CENTERS						
	11300   NTEREST EXPENSE						113.00
118. 00	,	242, 895	84, 673	462, 978	800, 865	29, 788, 434	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol	0	٥	22, 717	100 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	o	0			190.00
	19201 MI DWEST MEDI CAL CLINIC	o	o	0			192.01
194.00	07950 OTHER NONREI MBURSABLE	O	o	0	О	0	194. 00
	07951 ASSISTED LIVING UNITS	0	o	0	0	1, 030, 260	
	07952 ADULT DAY CARE	0	0	0	0	17, 059	
	07953 GRANT FUNDED PROGRAMS   07954 IDLE SPACE		O	0	0	0 104, 130	194.03
	07955 COMMUNITY FITNESS CENTER	0	0	0	0	82, 803	
50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<u>.                                    </u>	<u> </u>		<u>,                                    </u>	, 550	

Health Financial Systems	MIDWEST MEDIC	CAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		eri od:	Worksheet B	
			_	rom 10/01/2022	Part I	
			1	o 09/30/2023		
					2/23/2024 11:	09 am
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	Subtotal	
	SERVI CE &		RECORDS &	ANESTHETI STS		
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	19. 00	24.00	
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	C	0	0	201.00
202.00 TOTAL (sum lines 118 through 2	201) 242, 895	84, 673	462, 978	800, 865	31, 045, 403	202. 00

Health Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1302 Peri od: Worksheet B From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-ALU BLDG 1.01 1 01 1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL 1.02 00103 NEW CAP REL COSTS-2007 MOB 1.03 1.03 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO 2.01 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00550 INFORMATION TECHNOLOGY 5.02 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 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT-SCC 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00801 LAUNDRY & LINEN SERVICE-SCC 8 01 8.01 9.00 00900 HOUSEKEEPI NG 9.00 00901 HOUSEKEEPI NG-SCC 9.01 9.01 01000 DI ETARY 10.00 10.00 01001 DI ETARY-SCC 10.01 10.01 11.00 01100 CAFETERI A 11.00 01101 CAFETERI A-SCC 11.01 11.01 13 00 01300 NURSING ADMINISTRATION 13 00 01400 CENTRAL SERVICE & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 315, 003 30.00 04200 SUBPROVI DER 42.00 0 42.00 04400 SKILLED NURSING FACILITY 0 29, 756 44 00 44 00 04600 OTHER LONG TERM CARE 46.00 0 3, 433, 962 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 528, 107 50.00 0 05300 ANESTHESI OLOGY 887, 485 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000000 2, 288, 908 54.00 57.00 05700 CT SCAN Ω 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 06000 LABORATORY 1, 687, 031 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 84,700 64.00 06500 RESPIRATORY THERAPY 65.00 94. 142 65.00 3, 084, 232 66.00 06600 PHYSI CAL THERAPY 66.00 66.01 06601 CARDI AC REHAB 262, 163 66.01 67.00 06700 OCCUPATI ONAL THERAPY 270, 550 67.00 06800 SPEECH PATHOLOGY 149, 403 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1, 426, 588 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 111, 764 73.00 76.00 03020 SLEEP LAB C 76.00 76.01 03950 PAIN CLINIC / SERVICE 0 76.01 03530 SNF PHYSICAL THERAPY - SCC THERAPY 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 3, 141, 206 88.00 08801 RURAL HEALTH CLINIC II 0 88.01 894, 740 88.01 0 90.00 09000 CLI NI C 90.00 890, 860 0 09100 EMERGENCY 91.00 3, 207, 834 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04040 FAMILY PRACTICE 93.00 0 93.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 29, 788, 434 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 22, 717 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 C 0 192. 01 19201 MIDWEST MEDICAL CLINIC 0 192.01 194. 00 07950 OTHER NONREI MBURSABLE 194.00 Ω 194. 01 07951 ASSISTED LIVING UNITS 0 1,030,260 194.01

0

17,059

194.02

194.03

194. 02 07952 ADULT DAY CARE

194. 03 07953 GRANT FUNDED PROGRAMS

Health Financial Systems	MIDWEST MEDICA	L CENTER		In Lieu of Form CMS-2552		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Pre 2/23/2024 11:	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25,00	Total 26. 00				
194. 04 07954  I DLE SPACE	25.00	104, 130				194. 04
194.05 07955 COMMUNITY FITNESS CENTER 200.00 Cross Foot Adjustments	0	82, 803 0				194. 04 194. 05 200. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0	0 31, 045, 403				201. 00 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am Provider CCN: 14-1302

				OADI TAL DEL		2/23/2024 11:0	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FLXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		Related Costs 0	1. 00	1. 01	1. 02	1. 03	
	GENERAL SERVICE COST CENTERS		1.00	1.01	1.02	1.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	00101 NEW CAP REL COSTS-ALU BLDG 00102 NEW CAP REL COSTS-2007 HOSPITAL						1. 01 1. 02
1. 02	00103 NEW CAP REL COSTS-2007 MOB						1. 02
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 5. 01	OO4OO	0	0		0 33, 934	0	4. 00 5. 01
5. 02	00550 I NFORMATI ON TECHNOLOGY		61	0	16, 855	Ö	5. 02
5. 03	00590 HOSPITAL BILLING	0	0		0	0	5.03
5. 04	00540 OTHER ADMINISTRATIVE AND GENERAL	0	894		203, 652	0	5.04
6. 00 7. 00	OO6OO   MAINTENANCE & REPAIRS   OO7OO   OPERATION OF PLANT		0		157, 927	0	6. 00 7. 00
7. 01	00701 OPERATION OF PLANT-SCC	0	206		0	0	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	1	15, 959	0	8. 00
8. 01 9. 00	O0801   LAUNDRY & LI NEN SERVI CE-SCC   O0900   HOUSEKEEPI NG	0	21 0	0	0 12, 103	0	8. 01 9. 00
9. 00	00901 HOUSEKEEPI NG-SCC	0	39		12, 103	0	9. 01
10.00	01000 DI ETARY	0	0		143, 717	0	10.00
10. 01	01001 DI ETARY-SCC	0	152	l	0	0	10.01
11. 00 11. 01	01100   CAFETERI A   01101   CAFETERI A-SCC	0	0		0	0	11. 00 11. 01
13. 00	01300 NURSI NG ADMI NI STRATI ON	l o	68		5, 738	Ö	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0	-	30, 572	0	14.00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDICAL RECORDS & LIBRARY	0	0	0	34, 652 30, 797	0	15. 00 16. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS		0		30, 797	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	l	396, 724	0	30.00
42. 00 44. 00	04200   SUBPROVI DER   04400   SKILLED NURSING FACILITY	0	0 178		0	0	42. 00 44. 00
46. 00	04600 OTHER LONG TERM CARE	0	1, 857	l	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	O			241 252	0	EO 00
50. 00 53. 00	05000   OPERATI NG ROOM   05300   ANESTHESI OLOGY	0	0		241, 352 2, 421	0	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 169	0	0	162, 769	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58. 00 60. 00	05800   MAGNETI C RESONANCE   MAGING (MRI)   06000   LABORATORY		0	0	48, 234	0	58. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	8, 428	0	65.00
66. 00 66. 01	O6600  PHYSI CAL THERAPY   O6601  CARDI AC REHAB	0	0	0	193, 879 13, 448	0	66. 00 66. 01
67. 00	06700 OCCUPATI ONAL THERAPY		0	0	16, 676	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	0	0	0	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
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 76. 02	03950 PAIN CLINIC / SERVICE 03530 SNF PHYSICAL THERAPY - SCC THERAPY		0	0	0	0	76. 01 76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	9		<u> </u>		Ū	70.02
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	256, 996	0	88.00
88. 01 90. 00	O8801   RURAL HEALTH CLINIC II   O9000   CLINIC		0	0	44, 828	0	88. 01 90. 00
91.00	09100 EMERGENCY	l o	0	Ö	248, 389	Ö	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	O4040   FAMILY PRACTICE     SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	93.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00	3 /	1, 169	3, 476	15, 879	2, 320, 050	0	118. 00
190.00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	13, 314	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		0	0	0	0	192.00
	19201 MI DWEST MEDI CAL CLI NI C	0	0	0	0		192. 01
	07950 OTHER NONREIMBURSABLE 07951 ASSISTED LIVING UNITS		0	34, 171	0		194. 00 194. 01
	07952 ADULT DAY CARE		0	2, 766	Ö		194. 02

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 14-1302	Peri od: Worksheet B From 10/01/2022 Part II To 09/30/2023 Date/Time Prepared:

					2/23/2024 11:	09 am
		CAPI TAL RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	NEW ALU BLDG	NEW 2007	NEW 2007 MOB	
	Assigned New	FLXT		HOSPI TAL		
	Capi tal					
	Related Costs					
	0	1. 00	1. 01	1. 02	1. 03	
194. 03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194. 03
194. 04 07954 I DLE SPACE	0	1, 923	0	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	0	0	0	14, 524	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 through 201)	1, 169	5, 399	52, 816	2, 347, 888	0	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302

				10	0 09/30/2023	Date/lime Pre 2/23/2024 11:	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		2. 00	2. 01	2A	4. 00	5. 01	
	NERAL SERVICE COST CENTERS						
1	1100 NEW CAP REL COSTS-BLDG & FIXT 1101 NEW CAP REL COSTS-ALU BLDG						1.00 1.01
1	1102 NEW CAP REL COSTS-ALO BLDG						1.01
1	103 NEW CAP REL COSTS-2007 MOB						1.03
1	200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
1	400 EMPLOYEE BENEFITS DEPARTMENT 570 ADMITTING	0	0	0 33, 934	0	33, 934	4. 00 5. 01
1	550 INFORMATION TECHNOLOGY	0	75, 330		0	0 0	5.02
	590 HOSPITAL BILLING	0	0	0	0	0	5. 03
	0540 OTHER ADMINISTRATIVE AND GENERAL	1, 004	115, 824		0	0	5.04
	1600 MAINTENANCE & REPAIRS 1700 OPERATION OF PLANT	0	34, 880	0 192, 807	0	0	6. 00 7. 00
	701 OPERATION OF PLANT-SCC	301	0	507	Ö	0	7. 01
	800 LAUNDRY & LINEN SERVICE	0	506		0	0	8. 00
1	1801 LAUNDRY & LI NEN SERVI CE-SCC	0	0		0	0	8. 01
1	900 HOUSEKEEPI NG 1901 HOUSEKEEPI NG-SCC	0	294	12, 397 39	0	0	9. 00 9. 01
1	000 DI ETARY	0	28, 463		0	0	10.00
10. 01 01	001 DI ETARY-SCC	0	0	152	0	0	10. 01
1	100 CAFETERI A	0	0	_	0	0	11.00
- 1	101 CAFETERI A-SCC 300 NURSI NG ADMI NI STRATI ON	0	0	0 5, 806	0	0	11. 01 13. 00
	400 CENTRAL SERVICE & SUPPLY	0	0		0	0	14.00
1	500 PHARMACY	0	1, 760		o	0	15.00
	600 MEDICAL RECORDS & LIBRARY	0	122			0	16.00
	900 NONPHYSICIAN ANESTHETISTS PATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
	000 ADULTS & PEDIATRICS	0	54, 090	450, 814	0	3, 312	30.00
	200 SUBPROVI DER	0	0		o	0	42.00
1	400 SKILLED NURSING FACILITY	0	0			0	44.00
	600 OTHER LONG TERM CARE CILLARY SERVICE COST CENTERS	8, 740	0	10, 597	0	0	46.00
	OOO OPERATING ROOM	0	327, 945	569, 297	0	5, 450	50.00
1	300 ANESTHESI OLOGY	0	20, 149		0	1, 204	53.00
1	400 RADI OLOGY-DI AGNOSTI C	0	256, 905		0	6, 718	1
	700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57. 00 58. 00
	000 LABORATORY	0	21, 251	69, 485	o	4, 063	1
64. 00 06	400 INTRAVENOUS THERAPY	0	0	0	0	804	64.00
	500 RESPI RATORY THERAPY	0	5, 296		0	57	65.00
1	600 PHYSI CAL THERAPY 601 CARDI AC REHAB	0	10, 831 8, 545		0	3, 786 206	1
	700 OCCUPATI ONAL THERAPY	0	0, 343				67.00
68. 00 06	800 SPEECH PATHOLOGY	0	0	0			68.00
	900 ELECTROCARDI OLOGY	0	0	0	0	0	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	0	] 0	0	1, 867 0	71.00 72.00
1	300 DRUGS CHARGED TO PATIENTS	0	ő	Ö	o	3, 028	
76. 00 03	020 SLEEP LAB	0	0	0	o	0	
	950 PAIN CLINIC / SERVICE	0	0	0	0	0	
	530 SNF PHYSICAL THERAPY - SCC THERAPY TPATIENT SERVICE COST CENTERS	U	0	0	0	0	76. 02
	800 RURAL HEALTH CLINIC	14	8, 466	265, 476	0	0	88. 00
	801 RURAL HEALTH CLINIC II	0	1, 521		o	0	88. 01
	000 CLI NI C	0	8, 456		0	0	90.00
1	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)	U	21, 605	269, 994 0	=	2, 888	91.00 92.00
	040 FAMILY PRACTICE	0	0			0	1
	ECIAL PURPOSE COST CENTERS						
1	300 INTEREST EXPENSE	10 050	1 002 220	2 252 072		22 024	113.00
118. 00 NO	SUBTOTALS (SUM OF LINES 1 through 117)   NREIMBURSABLE COST CENTERS	10, 059	1, 002, 239	3, 352, 872	0	33, 934	118. 00
190. 00 19	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102	13, 416	0	0	190. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	О		192.00
	201 MI DWEST MEDI CAL CLI NI C	0	0	0	0		192. 01
1	950 OTHER NONREI MBURSABLE 951 ASSISTED LIVING UNITS	1, 140	7, 913	43, 224	0		194. 00 194. 01
	952 ADULT DAY CARE	687	1				194. 02
194. 03 07	953 GRANT FUNDED PROGRAMS	0	0				194. 03

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 14-1302	Period: Worksheet B From 10/01/2022 Part II
		To 09/30/2023 Date/Time Prepared

					077 007 2020	2/23/2024 11:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW MVBLE	NEW MVBLE	Subtotal	EMPLOYEE	ADMITTING	
		EQUI P	EQUIP NEW HO		BENEFITS		
					DEPARTMENT		
		2. 00	2. 01	2A	4. 00	5. 01	
194. 04 07954	I DLE SPACE	0	0	1, 92	3 0	0	194. 04
194. 05 07955	COMMUNITY FITNESS CENTER	0	1, 710	16, 23	4 0	0	194. 05
200. 00	Cross Foot Adjustments				0		200.00
201. 00	Negative Cost Centers	0	0		0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	11, 886	1, 011, 964	3, 431, 12			202.00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302

			To	09/30/2023	Date/Time Pre 2/23/2024 11:	
Cost Center Description	I NFORMATI ON	HOSPI TAL	OTHER	MAINTENANCE &	OPERATION OF	
	TECHNOLOGY	BI LLI NG	ADMINISTRATIV E AND GENERAL	REPAI RS	PLANT	
	5. 02	5. 03	5. 04	6. 00	7. 00	
GENERAL SERVICE COST CENTERS  1. 00   O0100   NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 O0101 NEW CAP REL COSTS-ALU BLDG						1.00
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 2.01   00201   NEW CAP REL COSTS-MVBLE EQUIP NEW	ПО					2. 00 2. 01
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	HU					4.00
5. 01   00570   ADMI TTI NG						5. 01
5.02 00550 INFORMATION TECHNOLOGY	92, 246					5. 02
5. 03 00590 HOSPITAL BILLING	0	0	050 004			5. 03
5. 04   00540 OTHER ADMINISTRATIVE AND GENERAL 6. 00   00600 MAINTENANCE & REPAIRS	13, 668	0	350, 921 0	0		5. 04 6. 00
7. 00   00700   OPERATION OF PLANT	2, 562	0	15, 081	0	210, 450	7.00
7. 01   OO701 OPERATION OF PLANT-SCC	0	0	0	0	0	7. 01
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	1, 544	0	1, 735	8. 00
8. 01   00801   LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8. 01
9. 00   00900   HOUSEKEEPI NG 9. 01   00901   HOUSEKEEPI NG-SCC	0	0	5, 387 0	0	1, 316 0	9. 00 9. 01
10. 00   01000 DI ETARY	1, 708	0	10, 281	0	15, 626	10.00
10. 01   01001   DI ETARY-SCC	0	0	0	0	0	10. 01
11. 00   01100   CAFETERI A	0	0	0	0	0	11.00
11. 01   01101   CAFETERI A-SCC 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0 427	0	0 7, 818	0	0	11.01
14. 00   01400   CENTRAL SERVICE & SUPPLY	427	0	7, 818 2, 891	0	624 3, 324	13.00 14.00
15. 00   01500   PHARMACY	1, 281	Ö	745	Ö	3, 768	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 708	0	5, 798	0	3, 349	16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	10, 635	0	0	19. 00
30.00 OSOOO ADULTS & PEDIATRICS	8, 541	O	34, 335	O	43, 136	30.00
42. 00   04200   SUBPROVI DER	0, 341	0	34, 333	0	43, 130	42.00
44.00 04400 SKILLED NURSING FACILITY	o	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 OPERATING ROOM	8, 114	O	27, 893	0	26, 242	50.00
53. 00 05300 ANESTHESI OLOGY	0, 114	0	27, 875 876	0	263	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 125	0	27, 410	0	17, 698	54.00
57. 00   05700   CT   SCAN	0	0	0	0	0	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI) 60. 00   06000   LABORATORY	0 2 125	0	0	0	0	58. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 135	0	21, 191 924	0	5, 245 0	64.00
65. 00 06500 RESPIRATORY THERAPY	Ö	0	1, 073	Ö	916	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 812	0	38, 313	0	22, 787	66. 00
66. 01   06601   CARDI AC   REHAB	1, 281	0	3, 317	0	1, 462	66.01
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	427 0	0	3, 378 1, 945	0	1, 813 0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	o o	o	0	ő	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 0	0	16, 765	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03020   SLEEP LAB	0	0	13, 129 0	0	0	73. 00 76. 00
76. 01 03950 PAIN CLINIC / SERVICE		0	0	0	0	76.00
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAP	Υ 0	0	0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS	10 (()	٥	20, 400	ما	07.040	00.00
88.00   08800   RURAL HEALTH CLINIC 88.01   08801   RURAL HEALTH CLINIC II	13, 666 4, 698	0	38, 423 11, 740	0	27, 943 0	88. 00 88. 01
90. 00   09000   CLI NI C	5, 979	0	11, 740	0	3, 168	ł
91. 00 09100 EMERGENCY	5, 125	0	37, 478	0	27, 008	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA						92.00
93. 00   04040  FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	93. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through NONREI MBURSABLE COST CENTERS	117) 89, 257	0	349, 725	0	207, 423	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EN O	0	198	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
192. 01 19201 MI DWEST MEDI CAL CLINI C	0	0	0	0		192.01
194. 00 07950 OTHER NONREIMBURSABLE 194. 01 07951 ASSISTED LIVING UNITS	0	O O	0	O O		194. 00 194. 01
194. 02 07952 ADULT DAY CARE		o	0	ol		194. 02
194.03 07953 GRANT FUNDED PROGRAMS	0	o	0	o	0	194. 03
194. 04 07954 I DLE SPACE	0	0	28	0		194. 04
194. 05 07955 COMMUNITY FITNESS CENTER	2, 989	0	970	0	1, 579	194. 05

Health Financial Systems	MIDWEST MEDICAL CENTER			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B		
				From 10/01/2022			
				Γο 09/30/2023			
					2/23/2024 11:	09 am	
Cost Center Description	I NFORMATION	HOSPI TAL	OTHER	MAINTENANCE &	OPERATION OF		
	TECHNOLOGY	BI LLI NG	ADMI NI STRATI V	REPAI RS	PLANT		
			E AND GENERAL				
	5. 02	5. 03	5. 04	6. 00	7. 00		
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0		0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	92, 246	0	350, 92	1 0	210, 450	202.00	

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To | 09/30/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302

				Ť	09/30/2023	Date/Time Prepa 2/23/2024 11:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-	7 dili
		PLANT-SCC	LINEN SERVICE	LI NEN SERVI CE-SCC		SCC	
		7. 01	8. 00	8. 01	9. 00	9. 01	
1. 00	GENERAL SERVICE COST CENTERS    OO100   NEW CAP REL COSTS-BLDG & FLXT						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 2. 01	OO200   NEW CAP REL COSTS-MVBLE EQUIP   OO201   NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG						5. 01
5. 02	00550 I NFORMATI ON TECHNOLOGY						5. 02
5. 03 5. 04	OO590   HOSPI TAL BILLING   OO540   OTHER ADMINISTRATIVE AND GENERAL						5. 03 5. 04
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7.00
7. 01	00701 OPERATION OF PLANT-SCC	507	10 744				7. 01
8. 00 8. 01	O0800   LAUNDRY & LI NEN SERVI CE   O0801   LAUNDRY & LI NEN SERVI CE-SCC	0	19, 744 0				8. 00 8. 01
9. 00	00900 HOUSEKEEPI NG	Ō	0				9. 00
9. 01	00901 HOUSEKEEPI NG-SCC	3	0	0		42	9. 01
10. 00 10. 01	01000 DI ETARY 01001 DI ETARY-SCC	0 12	0	0	,		10. 00 10. 01
11. 00	01100 CAFETERI A	0	0		_		11. 00
11. 01	01101 CAFETERI A-SCC	o	0	Ö			11. 01
13.00	01300 NURSI NG ADMI NI STRATI ON	5	0	0			13.00
14. 00 15. 00	O1400   CENTRAL SERVI CE & SUPPLY   O1500   PHARMACY	0	0	0			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		0	0		l I	16. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0				19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 42. 00	03000   ADULTS & PEDI ATRI CS   04200   SUBPROVI DER	0	19, 744 0		· ·		30. 00 42. 00
44. 00	04400 SKILLED NURSING FACILITY	14	0				44.00
	04600 OTHER LONG TERM CARE	144	0	23	0	l I	46.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	1 0			2 (40	0	FO 00
50. 00 53. 00	05000   OPERATI NG ROOM   05300   ANESTHESI OLOGY	0	0			l I	50. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o o	0	Ö		· · ·	54.00
57.00	05700 CT SCAN	0	0	0			57.00
58.00	05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0	0	_		58.00
60. 00 64. 00	06000   LABORATORY   06400   I NTRAVENOUS THERAPY	0	0	0			60. 00 64. 00
65.00	06500 RESPI RATORY THERAPY	Ö	0	Ö	_		65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0			66.00
66. 01	O6601   CARDI AC REHAB   O6700   OCCUPATI ONAL THERAPY	0	0	0	86		66. 01 67. 00
67. 00 68. 00	06800 SPEECH PATHOLOGY	0	0		66		68.00
	06900 ELECTROCARDI OLOGY	Ö	0	Ö	Ö	-	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		72. 00 73. 00
	03020 SLEEP LAB		0		0	l I	76. 00
76. 01	03950 PAIN CLINIC / SERVICE	o	0	Ö		l I	76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76. 02
00 NN	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		0	Ο	2, 905	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC	0	0				88. 01
	09000 CLINIC	o	0	Ö	295	0	90.00
	09100 EMERGENCY	0	0	0	2, 725		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE		0	0	0	l .	92. 00 93. 00
93.00	SPECIAL PURPOSE COST CENTERS	l ol	0	0	0	0	93.00
113.00	11300 I NTEREST EXPENSE					1	13.00
118.00	, , , , , , , , , , , , , , , , , , ,	180	19, 744	23	19, 042	22 1	18.00
100.00	NONREI MBURSABLE COST CENTERS		0			0.1	00 00
	1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN   1920  PHYSICIANS' PRIVATE OFFICES	0	0				90. 00 92. 00
	19201 MI DWEST MEDICAL CLINIC		0	Ö		l	92. 01
194.00	07950 OTHER NONREI MBURSABLE	0	0	0	0	0 1	94.00
194. 01	07951 ASSISTED LIVING UNITS	157	0	0	0		94. 01
	07952 ADULT DAY CARE 07953 GRANT FUNDED PROGRAMS	13	0	0	0		94. 02 94. 03
	07954 I DLE SPACE	157	0	Ö	0	0 1	94.04
	07955 COMMUNITY FITNESS CENTER	0	0	0	58		94. 05

Health Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Pre 2/23/2024 11:	
Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LI NEN	HOUSEKEEPI NG	HOUSEKEEPI NG- SCC	

						2/23/2024 11:	<u>09 am</u>
	Cost Center Description	OPERATION OF	LAUNDRY &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-	
		PLANT-SCC	LINEN SERVICE	LI NEN		SCC	
				SERVI CE-SCC			
		7. 01	8. 00	8. 01	9. 00	9. 01	
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 through 201)	507	19, 744	23	19, 100	42	202.00

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To | 09/30/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302

					Τ̈́	o 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Cost Center Description	DI ETARY	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	NURSI NG ADMI NI STRATI O	O7 alli
			10.00	10.01	11 00	11 01	N	
	GENER	AL SERVICE COST CENTERS	10. 00	10. 01	11. 00	11. 01	13. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	1	NEW CAP REL COSTS-ALU BLDG						1. 01
1. 02	1	NEW CAP REL COSTS 2007 HOSPITAL						1.02
1. 03 2. 00	1	NEW CAP REL COSTS-2007 MOB NEW CAP REL COSTS-MVBLE EQUIP						1. 03 2. 00
2. 01		NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		ADMITTI NG						5. 01
5. 02		INFORMATION TECHNOLOGY						5.02
5. 03 5. 04		HOSPITAL BILLING OTHER ADMINISTRATIVE AND GENERAL						5. 03 5. 04
6. 00	1	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7. 01	1	OPERATION OF PLANT-SCC						7. 01
8. 00 8. 01	1	LAUNDRY & LINEN SERVICE LAUNDRY & LINEN SERVICE-SCC						8. 00 8. 01
9. 00		HOUSEKEEPING						9.00
9. 01		HOUSEKEEPI NG-SCC						9. 01
10.00		DI ETARY	201, 372					10.00
10. 01	1	DI ETARY-SCC	0	165				10.01
11. 00 11. 01	1	CAFETERI A CAFETERI A-SCC	U O	0		0		11.00
13. 00		NURSING ADMINISTRATION	o	0		0	14, 744	1
14.00	1	CENTRAL SERVICE & SUPPLY	o	0	C	0	0	1
15. 00	1	PHARMACY	0	0	C		0	1
16.00	1	MEDICAL RECORDS & LIBRARY	0	0	C		0	16.00
19. 00		NONPHYSICIAN ANESTHETISTS   ENT ROUTINE SERVICE COST CENTERS	U	0	C	0	0	19.00
30. 00		ADULTS & PEDIATRICS	201, 372	0	С	0	8, 221	30.00
42.00		SUBPROVI DER	0	0			0	42.00
44.00	1	SKILLED NURSING FACILITY	0	0	_		0	
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	0	106	C	0	0	46.00
50.00		OPERATING ROOM	0	0	C	0	3, 214	50.00
53.00		ANESTHESI OLOGY	О	0	C		0	53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0 0	57. 00 58. 00
60.00	1	LABORATORY	0	0		0	0	60.00
64. 00	1	INTRAVENOUS THERAPY	ō	0	Ċ	0	0	64.00
65. 00	1	RESPI RATORY THERAPY	0	0	C		0	
66.00		PHYSI CAL THERAPY	0	0	C	_	0	66.00
66. 01 67. 00	1	CARDI AC REHAB OCCUPATI ONAL THERAPY	0	0		_	0	66. 01 67. 00
68. 00	1	SPEECH PATHOLOGY	o	Ö	Č		ő	1
	1	ELECTROCARDI OLOGY	o	0	C	0	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0		0	0 0	
	1	SLEEP LAB	o	0		0	0	1
76. 01	03950	PAIN CLINIC / SERVICE	o	0	C	0	0	
76. 02		SNF PHYSICAL THERAPY - SCC THERAPY	0	0	C	0	0	76. 02
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	٥	0	С	0	0	88. 00
88. 00	1	RURAL HEALTH CLINIC	0	0		0	0	
90.00		CLI NI C	Ö	Ö	Ċ	Ö	Ö	90.00
91. 00		EMERGENCY	0	0	C	0	3, 309	
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00		FAMILY PRACTICE AL PURPOSE COST CENTERS	U <sub>I</sub>	U	C	) U	0	93.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201, 372	106	С	0	14, 744	118.00
100 00		I MBURSABLE COST CENTERS	٥	0			0	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0				190. 00 192. 00
	1	MIDWEST MEDICAL CLINIC	o	0		o o		192.00
194.00	07950	OTHER NONREIMBURSABLE	o	0	C	0		194. 00
		ASSISTED LIVING UNITS	0	59	<u> </u>	0		194. 01
		ADULT DAY CARE GRANT FUNDED PROGRAMS	0	0		0		194. 02 194. 03
	1	I DLE SPACE	o	0		o		194. 03
		COMMUNITY FITNESS CENTER	o	0	C	0		194. 05

Health Financial Systems	MIDWEST MEDICAL CENTER			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 14-1302		Peri od: Worksheet B			
				From 10/01/2022			
				To 09/30/2023	Date/Time Pre 2/23/2024 11:		
Cost Center Description	DI ETARY	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	NURSI NG		
					ADMI NI STRATI O		
					N		
	10.00	10. 01	11. 00	11. 01	13.00		
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 through 201)	201, 372	165		0 0	14, 744	202. 00	

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To | 09/30/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302

			Ť	o 09/30/2023	Date/Time Pre 2/23/2024 11:	
Cost Center Description	CENTRAL SERVI CE & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	Subtotal	O7 dill
	14. 00	15. 00	16. 00	19. 00	24. 00	
GENERAL SERVICE COST CENTERS  1. 00	37, 122		10.00	17.00	2-4.00	1. 00 1. 01 1. 02 1. 03 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 7. 01 8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 13. 00 14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	153	42, 586 0	42, 265			15. 00 16. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	ō				19.00
30. 00 03000 ADULTS & PEDIATRICS	1, 251	ol	3, 828		778, 906	30.00
42. 00   04200   SUBPROVI DER	0	0	0		0	42.00
44.00   04400   SKILLED NURSING FACILITY 46.00   04600   OTHER LONG TERM CARE	0	0	0		194 10, 888	44. 00 46. 00
ANCILLARY SERVICE COST CENTERS		-				
50. 00   05000   OPERATI NG ROOM 53. 00   05300   ANESTHESI OLOGY	4, 444 526	0	6, 300 1, 391		653, 602 26, 857	50. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	833	0	7, 780		488, 193	54.00
57. 00 05700 CT SCAN	0	0	0		0	57.00
58.00   O5800   MAGNETI C RESONANCE I MAGING (MRI) 60.00   O6000   LABORATORY	0	0	0 4, 696		0 107, 344	58. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	756	o	929		3, 413	64.00
65. 00 06500 RESPIRATORY THERAPY	862	0	66		16, 790	65.00
66. 00   06600   PHYSI CAL THERAPY 66. 01   06601   CARDI AC REHAB	1, 522	0	4, 376 238		289, 144 28, 583	66. 00 66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	104	o	391		23, 193	67.00
68. 00 06800 SPEECH PATHOLOGY	40	0	247		2, 445	1
69.00   06900   ELECTROCARDI OLOGY 71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	21, 456	0	2, 158		0 42, 246	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0		0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03020   SLEEP LAB	8	42, 586	3, 500		62, 251	73.00
76. 00   03020  SLEEP LAB 76. 01   03950  PALN CLINIC / SERVICE		0	0		0	76. 00 76. 01
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		0	76. 02
88.00 OBSOO RURAL HEALTH CLINIC	1, 624	٥١	2, 162		352, 199	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	509	o	663		19, 131	88. 01
90. 00 09000 CLI NI C	1, 538	0	201		75, 820	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	1, 496	0	3, 339		353, 362	91. 00 92. 00
93. 00 04040 FAMILY PRACTICE	O	0	0		0	93.00
SPECIAL PURPOSE COST CENTERS						112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	37, 122	42, 586	42, 265	0	3, 334, 561	113. 00 118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ام	0		15, 062	100 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	0			192.00
192.01 19201 MIDWEST MEDICAL CLINIC	0	0	0			192.01
194. 00 07950 0THER NONREIMBURSABLE 194. 01 07951 ASSISTED LIVING UNITS	0	0	0		0 43, 458	194. 00 194. 01
194. 02 07952 ADULT DAY CARE		o	0		3, 468	194. 02
194. 03 07953 GRANT FUNDED PROGRAMS	0	o	0			194.03
194. 04 07954 IDLE SPACE 194. 05 07955 COMMUNITY FITNESS CENTER	0	ol Ol	0		2, 108 21, 830	194. 04 194. 05

Health Financial Systems	MI DWEST ME	EDICAL CENTER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der (		Peri od:	Worksheet B	
					Part II	
			1	o 09/30/2023	Date/Time Pre	
					2/23/2024 11:	<u>09 am</u>
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN	Subtotal	
	SERVI CE &		RECORDS &	ANESTHETI STS		
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	19.00	24.00	
200.00 Cross Foot Adjustments				10, 635	10, 635	200.00
201.00 Negative Cost Centers		0	0 0	0	0	201.00
202.00 TOTAL (sum lines 118 throu	gh 201) 37, 1	22 42, 586	6 42, 265	10, 635	3, 431, 122	202.00

Health Financial Systems In Lieu of Form CMS-2552-10 MIDWEST MEDICAL CENTER ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1302 Peri od: Worksheet B From 10/01/2022 Part II 09/30/2023 Date/Time Prepared: 2/23/2024 11:09 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-ALU BLDG 1.01 1 01 1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL 1.02 00103 NEW CAP REL COSTS-2007 MOB 1.03 1.03 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO 2.01 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00550 INFORMATION TECHNOLOGY 5.02 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 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT-SCC 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00801 LAUNDRY & LINEN SERVICE-SCC 8 01 8.01 9.00 00900 HOUSEKEEPI NG 9.00 00901 HOUSEKEEPI NG-SCC 9.01 9.01 01000 DI ETARY 10.00 10.00 01001 DI ETARY-SCC 10.01 10.01 11.00 01100 CAFETERI A 11.00 01101 CAFETERI A-SCC 11.01 11.01 13.00 01300 NURSING ADMINISTRATION 13 00 01400 CENTRAL SERVICE & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 778, 906 30.00 04200 SUBPROVI DER 42.00 0 Ω 42.00 04400 SKILLED NURSING FACILITY 0 44 00 194 44 00 04600 OTHER LONG TERM CARE 46.00 0 10,888 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 653, 602 50.00 0 53. 00 | 05300 | ANESTHESI OLOGY 53.00 26, 857 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 488, 193 54.00 57.00 05700 CT SCAN 0 0 Ω 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 06000 LABORATORY 107, 344 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 00000000000 3, 413 64.00 06500 RESPIRATORY THERAPY 16, 790 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 289, 144 66 00 66.01 06601 CARDI AC REHAB 28, 583 66.01 67.00 06700 OCCUPATI ONAL THERAPY 23, 193 67.00 06800 SPEECH PATHOLOGY 2, 445 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 42, 246 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 62, 251 73.00 76.00 03020 SLEEP LAB C 76.00 76.01 03950 PAIN CLINIC / SERVICE 0 0 76.01 03530 SNF PHYSICAL THERAPY - SCC THERAPY 76.02 76.02 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 352, 199 88.00 08801 RURAL HEALTH CLINIC II 19, 131 88.01 0 0 0 88.01 90. 00 09000 CLINIC 90.00 75, 820 91. 00 09100 EMERGENCY 91.00 353, 362 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00

92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	U		92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 334, 561	118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 062	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	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	43, 458	194. 01
194. 02	07952 ADULT DAY CARE	0	3, 468	194. 02
194. 03	07953 GRANT FUNDED PROGRAMS	0	0	194. 03
		·		

Health Financial Systems	MIDWEST MEDICAL	CENTER		In Lieu	ı of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 14-1302	Peri od: From 10/01/2022	Worksheet B	
					Date/Time Pre	epared:
					2/23/2024 11:	09 am
Cost Center Description	Intern &	Total				
	Resi dents					
	Cost & Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
194. 04 07954 I DLE SPACE	0	2, 108				194. 04
194.05 07955 COMMUNITY FITNESS CENTER	0	21, 830				194. 05
200.00 Cross Foot Adjustments	o	10, 635				200.00
201.00 Negative Cost Centers	o	o				201.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 431, 122				202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-1302

				СФР	TITAL RELATED CO	0 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Cost Center Description	NEW BLDG & FLXT	NEW ALU BLDG (SQUARE	NEW 2007 HOSPI TAL	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP	
			(SQUARE FEET)	FEET)	(SQUARE FEET)	(SQUARE TELT)	(DOLLAR	
			1.00	1 01	1.00	1.00	VALUE)	
	GENER	AL SERVICE COST CENTERS	1. 00	1. 01	1. 02	1. 03	2. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	50, 914					1.00
1. 01 1. 02	1	NEW CAP REL COSTS-ALU BLDG NEW CAP REL COSTS-2007 HOSPITAL	0	29, 602				1. 01 1. 02
1. 02	1	NEW CAP REL COSTS-2007 HOSPITAL	0			0		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					69, 389	2. 00
2. 01 4. 00	1	NEW CAP REL COSTS-MVBLE EQUIP NEW HO EMPLOYEE BENEFITS DEPARTMENT	0		0	0	0	2. 01 4. 00
5. 01		ADMITTING	0		757		0	5. 01
5. 02		INFORMATION TECHNOLOGY	578		376	0	0	5. 02
5. 03 5. 04	1	HOSPITAL BILLING OTHER ADMINISTRATIVE AND GENERAL	0 8, 429	0 8, 900	1	0	0 5, 864	5. 03 5. 04
6. 00	1	MAINTENANCE & REPAIRS	0, 427	0, 700		o	0	6.00
7. 00	1	OPERATION OF PLANT	0	0	1 -7		0	7. 00
7. 01 8. 00	1	OPERATION OF PLANT-SCC LAUNDRY & LINEN SERVICE	1, 940	0	0 356	-	1, 758 0	ı
8. 01		LAUNDRY & LINEN SERVICE-SCC	194	0	0		0	ı
9. 00	1	HOUSEKEEPI NG	0	0	270	0	0	9. 00
9. 01 10. 00	1	HOUSEKEEPI NG-SCC   DI ETARY	369	0	0 3, 206	0	0	9. 01 10. 00
10. 00		DI ETARY-SCC	1, 434	0	3, 200	0	0	10.00
11. 00		CAFETERI A	0	0	0	0	0	11. 00
11. 01 13. 00		CAFETERIA-SCC NURSING ADMINISTRATION	0 643	0	0 128	0	0	11. 01 13. 00
14. 00		CENTRAL SERVICE & SUPPLY	043	0	682		0	14. 00
15. 00		PHARMACY	0	0	773		0	15. 00
16. 00 19. 00		MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS	0	0			0	16. 00 19. 00
19.00		IENT ROUTINE SERVICE COST CENTERS				<u> </u>	0	19.00
30.00		ADULTS & PEDI ATRI CS	0	1	1		0	
42. 00 44. 00	1	SUBPROVIDER  SKILLED NURSING FACILITY	0 1, 683	0	1		0	42. 00 44. 00
46. 00		OTHER LONG TERM CARE	17, 508				51, 022	
F0 00		LARY SERVICE COST CENTERS		1 0	F 204		0	1 50 00
50. 00 53. 00		OPERATING ROOM ANESTHESIOLOGY	0	0			0	50. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	Ö	Ö	3, 631	-	0	54.00
57.00		CT SCAN	0	0	0	0	0	57.00
58. 00 60. 00	1	MAGNETIC RESONANCE IMAGING (MRI) LABORATORY	0		1, 076	0	0	58. 00 60. 00
64. 00	1	I NTRAVENOUS THERAPY	Ō	O	0	O	0	64. 00
65.00		RESPIRATORY THERAPY	0	0	188		0	65.00
66. 00 66. 01		PHYSI CAL THERAPY CARDI AC REHAB	0		4, 325 300		0	66. 00 66. 01
67. 00	06700	OCCUPATI ONAL THERAPY	0	0	372		0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		Ö	0	0	71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73. 00 76. 00		DRUGS CHARGED TO PATIENTS SLEEP LAB	0	0	0	0	0	73. 00 76. 00
76. 01	03950	PAIN CLINIC / SERVICE	0	0	ő	0	0	76.00
76. 02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76. 02
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	5, 733	0	80	88. 00
88. 01		RURAL HEALTH CLINIC	0		0, 733	0	0	1
90.00		CLINIC	0	0	1, 000		0	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	0	5, 541	0	0	91.00 92.00
		FAMILY PRACTICE	0	o	О	0	0	•
		AL PURPOSE COST CENTERS		ı	1			
113. 00 118. 00		INTEREST EXPENSE  SUBTOTALS (SUM OF LINES 1 through 117)	32, 778	8, 900	51, 755	0	58 724	113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	52,770	0, 700	31,755	<u> </u>		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297			190.00
		PHYSICIANS' PRIVATE OFFICES MIDWEST MEDICAL CLINIC	0	0	0	0		192. 00 192. 01
194.00	07950	OTHER NONREIMBURSABLE	0	0	Ö	o o	0	194.00
		ASSISTED LIVING UNITS	0	19, 152	1	0		194. 01
194.02	<u>4</u> 07952	ADULT DAY CARE	1 0	1, 550	0	i 0	4,011	194. 02

Heal th Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302 | Period: From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

				'	0 077 007 2020	2/23/2024 11:	
·			CAP	TAL RELATED CO	OSTS		
Cost Center	Description	NEW BLDG &	NEW ALU BLDG	NEW 2007	NEW 2007 MOB	NEW MVBLE	
cost center	besett pti on	FLXT	(SQUARE	HOSPI TAL	(SQUARE FEET)	EQUI P	
		(SQUARE FEET)	FEET)	(SQUARE FEET)	(SQUARE TEET)	(DOLLAR	
		(SQUARE TEET)	1 221)	(000/11/2 1221)		VALUE)	
		1. 00	1. 01	1. 02	1. 03	2. 00	
194. 03 07953 GRANT FUNDED	PROGRAMS	0	0	0	0	0	194. 03
194.04 07954 I DLE SPACE		18, 136	0	0	0	0	194. 04
194. 05 07955 COMMUNITY FI	TNESS CENTER	0	0	324	0	0	194. 05
200.00 Cross Foot A	djustments						200. 00
201.00 Negative Cos	t Centers						201.00
	llocated (per Wkst. B,	5, 399	52, 816	2, 347, 888	0	11, 886	202. 00
Part I)							
	Itiplier (Wkst. B, Part I)	0. 106042	1. 784204	44. 827555	0. 000000		ı
	llocated (per Wkst. B,						204. 00
Part II)							
	ltiplier (Wkst. B, Part						205. 00
206.00 NAHE adjustm	ont omount to be allegated						204 00
	ent amount to be allocated						206. 00
(per Wkst. B 207.00 NAHE unit co	-2) st multiplier (Wkst. D,						207. 00
Parts III an							207.00

	n Financial Systems	MIDWEST MEDIC				u of Form CMS-2	
COST /	ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 10/01/2022 o 09/30/2023	Worksheet B-1 Date/Time Pre 2/23/2024 11:	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (GROSS CHARGES)	I NFORMATI ON TECHNOLOGY (NO. OF COMPUTERS)	HOSPI TAL BI LLI NG (GROSS CHARGES HOSP BI LLI NG)	
		2. 01	4.00	5. 01	5. 02	5. 03	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 1. 02 1. 03 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 6. 00 7. 00 7. 01 8. 00 9. 01 10. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-ALU BLDG 00102 NEW CAP REL COSTS-2007 HOSPITAL 00103 NEW CAP REL COSTS-2007 MOB 00200 NEW CAP REL COSTS-WBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00550 INFORMATION TECHNOLOGY 00590 HOSPITAL BILLING 00540 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00701 OPERATION OF PLANT-SCC 00800 LAUNDRY & LINEN SERVICE 00801 LAUNDRY & LINEN SERVICE-SCC 00900 HOUSEKEEPING 00901 HOUSEKEEPING-SCC 01000 DIETARY 01001 DIETARY-SCC	894, 695 0 0 66, 601 0 102, 402 0 30, 838 0 447 0 260 0 25, 165	12, 636, 732 489, 615 345, 111 0 837, 150 0 155, 289 98, 666 0 0 238, 607 92, 634 308, 137 333, 861	39, 789, 133 0 0	216 0 32 0 6 0 0 0 0 0	42, 857, 849 0 0 0 0 0 0 0 0	1. 00 1. 01 1. 02 1. 03 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 7. 01 8. 00 8. 01 9. 00 9. 01 10. 00 10. 00
10. 01 11. 00 11. 01 13. 00 14. 00 15. 00 16. 00 19. 00	01100 CAFETERI A 01101 CAFETERI A-SCC 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0 0 0 0 0 1,556 108 0	335, 861 0 395, 838 116, 226 0 252, 565 525, 962	0 0 0	0 0 1 0 3 4 0	0 0 0 0 0 0 0	11. 00 11. 01 13. 00 14. 00 15. 00 16. 00 19. 00
30. 00 42. 00 44. 00	03000 ADULTS & PEDIATRICS	47, 822 0 0	1, 129, 322 0 0	3, 882, 439 0 0	20 0 0	3, 882, 439 0 0	30. 00 42. 00 44. 00
46.00	04600 OTHER LONG TERM CARE	0	1, 878, 388	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 53. 00 54. 00 57. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	289, 942 17, 814 227, 134	519, 824 0 472, 300	6, 389, 235 1, 410, 917 7, 883, 494	19 0 12	6, 389, 235 1, 410, 917 7, 883, 494 0	53.00
58. 00 60. 00 64. 00 65. 00 66. 01 67. 00 68. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06601 CARDIAC REHAB 06700 OCCUPATIONAL THERAPY	0 18, 788 0 4, 682 9, 576 7, 555 0	422, 853 0 0 0 1, 603, 872 134, 034 133, 899 90, 839	942, 417 66, 698 4, 438, 532 241, 760 396, 117	0 5 0 0 30 3 1	4, 762, 694 942, 417 66, 698 4, 438, 532 241, 760 396, 117 250, 138	58. 00 60. 00 64. 00 65. 00 66. 01 67. 00
69. 00 71. 00 72. 00 73. 00 76. 00 76. 01	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03020 SLEEP LAB 03950 PAIN CLINIC / SERVICE	0 0 0 0 0 0 0	0 0 0 0 0 0	250, 00 2, 188, 525 0 3, 550, 175 0 0	0 0 0 0 0 0	250, 0 0 2, 188, 525 0 3, 550, 175 0 0	69. 00 71. 00 72. 00
88. 00 88. 01 90. 00 91. 00 92. 00 93. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS	7, 485 1, 345 7, 476 19, 101	598, 072 221, 808 262, 421 542, 386	0	32 11 14 12 0	2, 192, 669 672, 548 203, 499 3, 385, 992	88. 01 90. 00
113. 00 118. 00	11300 INTEREST EXPENSE	886, 097	12, 199, 679	39, 789, 133	209	42, 857, 849	113. 00 118. 00
192. 00 192. 0	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 19200 PHYSICIANS' PRIVATE OFFICES 1 19201 MIDWEST MEDICAL CLINIC D 07950 OTHER NONREIMBURSABLE	90 0 0	0 0 0	0 0 0	0 0 0	0	190. 00 192. 00 192. 01 194. 00
	1 07951 ASSISTED LIVING UNITS	6, 996	424, 743		0		194. 01

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 14-1302	Period: Worksheet B-1 From 10/01/2022

				T	09/30/2023	Date/Time Pre 2/23/2024 11:	
		CAPI TAL				27 207 2021 11.	0 / 4111
		RELATED COSTS					
	Cost Center Description	NEW MVBLE	EMPLOYEE	ADMI TTI NG	I NFORMATI ON	HOSPI TAL	
		EQUIP NEW HO	BENEFITS	(GROSS	TECHNOLOGY	BI LLI NG	
		(DOLLAR	DEPARTMENT	CHARGES)	(NO. OF	(GROSS	
		VALUE)	(GROSS		COMPUTERS)	CHARGES HOSP	
			SALARI ES)			BI LLI NG)	
	I	2. 01	4. 00	5. 01	5. 02	5. 03	
	ADULT DAY CARE	0	0	0	0		194. 02
-	GRANT FUNDED PROGRAMS	0	0	0	0		194. 03
	IDLE SPACE	0	0	0	0		194. 04
-	COMMUNITY FITNESS CENTER	1, 512	12, 310	0	7		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,	1, 011, 964	3, 597, 764	672, 124	1, 015, 536	393, 455	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 131071	0. 284707				1
204. 00	Cost to be allocated (per Wkst. B,		0	33, 934	92, 246	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000000	0. 000853	427. 064815	0. 000000	205.00
201 00	[11]						00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	[					1

| Period: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1302

			Ť.	09/30/2023	Date/Time Pre 2/23/2024 11:	
Cost Center Description	Reconciliatio		MAINTENANCE &	OPERATION OF	OPERATION OF	09 alli
	n	ADMINISTRATIV	REPAIRS	PLANT	PLANT-SCC	
		(ACCUM COST)	(SQUARE FEET)	(SQUARE FT)	(SQUARE FT SCC)	
	5A. 04	5. 04	6.00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS	I	I	T			4 00
1.00   OO100   NEW CAP REL COSTS-BLDG & FIXT 1.01   OO101   NEW CAP REL COSTS-ALU BLDG						1. 00 1. 01
1. 02   00102 NEW CAP REL COSTS - 2007 HOSPI TAL						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 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
5. 01   00570   ADMI TTI NG						5. 01
5. 02 00550 I NFORMATI ON TECHNOLOGY						5. 02
5. 03   00590   HOSPITAL BILLING 5. 04   00540   OTHER ADMINISTRATIVE AND GENERAL	-2, 640, 729	23, 785, 999				5. 03 5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	-2, 040, 727		О			6.00
7.00 OO700 OPERATION OF PLANT	0	1, 022, 228	0	43, 177		7. 00
7. 01   00701   0PERATI ON OF PLANT-SCC 8. 00   00800   LAUNDRY & LI NEN SERVI CE	-330, 364	0 104, 645	0	0 356	61, 529 0	7. 01 8. 00
8. 01   00800   LAUNDRY & LINEN SERVICE 8. 01   00801   LAUNDRY & LINEN SERVICE-SCC	-32, 834		0	0	194	8. 00
9. 00   00900   HOUSEKEEPI NG	0	365, 113	0	270	0	9. 00
9. 01   00901   HOUSEKEEPI NG-SCC	-141, 098	l e	0	0	369	9. 01
10. 00   01000   DI ETARY 10. 01   01001   DI ETARY-SCC	-683, 881	696, 849	0	3, 206	0 1, 434	10. 00 10. 01
11. 00 01100 CAFETERI A	0	Ö	ő	0	0	11.00
11. 01   01101   CAFETERI A-SCC	0	0	0	0	0	11. 01
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CE & SUPPLY	0	529, 914	1	128	643	13.00
14. 00   01400   CENTRAL SERVI CE & SUPPLY 15. 00   01500   PHARMACY		195, 953 50, 517	1	682 773	0	14. 00 15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	· ·	1		0	16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	720, 838	0	0	0	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00   03000   ADULTS & PEDI ATRI CS	0	2, 327, 337	0	8, 850	0	30.00
42. 00   04200   SUBPROVI DER	0			0, 030	0	42.00
44.00 04400 SKILLED NURSING FACILITY	-14, 983		_	О	1, 683	44. 00
46. 00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	-2, 800, 039	0	0	0	17, 508	46. 00
50. 00 05000 OPERATING ROOM	0	1, 890, 674	0	5, 384	0	50.00
53. 00   05300   ANESTHESI OLOGY	0		1	54	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	1, 857, 942	1	3, 631	0	54.00
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	57. 00 58. 00
60. 00   06000   LABORATORY	0	1, 436, 376	ő	1, 076	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	62, 618		0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	72, 759 2, 596, 933	1	188 4, 675	0	65. 00 66. 00
66. 01   06601   CARDI AC   REHAB			1	300	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	228, 954	0		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0			0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0	0	0	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	889, 893	0	0	0	73.00
76. 00   03020   SLEEP LAB 76. 01   03950   PALN CLINIC / SERVICE	0	0	0	0	0	76. 00 76. 01
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	1		0	0	76.01
OUTPATIENT SERVICE COST CENTERS		-		-		
88. 00 08800 RURAL HEALTH CLINIC	0	_, _,		5, 733	0	88.00
88. 01   08801   RURAL HEALTH CLINIC II 90. 00   09000   CLINIC	0	795, 793 769, 678	1	650	0	88. 01 90. 00
91. 00 09100 EMERGENCY	Ö		1	5, 541	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00   O4040   FAMILY PRACTICE   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	93.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 643, 928	23, 704, 930	0	42, 556	21, 831	
NONREI MBURSABLE COST CENTERS	1	40.447	1	007		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	13, 416	0	297 0		190. 00 192. 00
192. 01 19201 MI DWEST MEDI CAL CLINIC	0	0	Ö	o		192.00
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	О		194.00
194. 01 07951  ASSISTED LIVING UNITS 194. 02 07952  ADULT DAY CARE	-612, 023 -3, 453	l e	0	0	19, 152 1, 550	194. 01 194. 02
194. 03 07953 GRANT FUNDED PROGRAMS	-3, 455		Ö	o	0	194. 03
194. 04 07954 I DLE SPACE	0	1, 923	0	0	18, 996	

Health Financial Systems	MIDWEST MEDIC	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 14-1302	Peri od:	Worksheet B-1	
				From 10/01/2022		
				To 09/30/2023	Date/Time Pre	
					2/23/2024 11:	09 am_
Cost Center Description	Reconciliatio	OTHER	MAI NTENANCE	& OPERATION OF	OPERATION OF	
		ADMINICTDATIV	DEDALDE	DI ANT	DI ANT CCC	

						2/23/2024 11:	<u>09 am</u>
	Cost Center Description	Reconciliatio	OTHER	MAINTENANCE &	OPERATION OF	OPERATION OF	
		n	ADMI NI STRATI V	REPAI RS	PLANT	PLANT-SCC	
			E AND GENERAL	(SQUARE FEET)	(SQUARE FT)	(SQUARE FT	
			(ACCUM COST)			SCC)	
		5A. 04	5. 04	6. 00	7. 00	7. 01	
194. 05 07955	COMMUNITY FITNESS CENTER	0	65, 730	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,		2, 640, 729	0	1, 135, 716	330, 364	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 111020	0. 000000	26. 303727	5. 369241	203. 00
204.00	Cost to be allocated (per Wkst. B,		350, 921	0	210, 450	507	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 014753	0.000000	4. 874123	0.008240	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	Financial Systems	MI DWEST MEDI			In Lie	u of Form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 10/01/2022 o 09/30/2023	Worksheet B-1 Date/Time Pre 2/23/2024 11:	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LI NEN SERVI CE-SCC (PATI ENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPI NG- SCC (SQUARE FT SCC)	DI ETARY (PATI ENT DAYS)	J
		8. 00	8. 01	9. 00	9. 01	10. 00	
1 00	GENERAL SERVICE COST CENTERS		Ι	I	I		1 4 00
1. 00 1. 01 1. 02 1. 03 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 7. 01 8. 00 9. 01 10. 00 11. 01 13. 00 14. 00 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 19. 00 10 1	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-ALU BLDG 00102 NEW CAP REL COSTS-2007 HOSPITAL 00103 NEW CAP REL COSTS-2007 MOB 00200 NEW CAP REL COSTS-2007 MOB 00201 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP 00500 NEW CAP REL COSTS-MVBLE EQUIP 00500 NEW CAP REL COSTS-MVBLE EQUIP 00500 NEW CAP REL COSTS-MVBLE EQUIP 00500 NOSPITAL BILLING 00500 NOSPITAL BILLING 00500 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00701 OPERATION OF PLANT-SCC 00800 LAUNDRY & LINEN SERVICE 00800 LAUNDRY & LINEN SERVICE-SCC 00900 HOUSEKEEPING 00901 HOUSEKEEPING 00901 DIETARY 01001 DIETARY-SCC 01100 CAFETERIA 01101 CAFETERIA-SCC 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 617 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	38, 840 0 3, 206 0 0 0 128 682 773 687	41, 970 0 1, 434 0 0 643 0 0	2, 617 0 0 0 0 0 0	1. 00 1. 01 1. 02 1. 03 2. 00 2. 01 4. 00 5. 01 5. 02 5. 03 6. 00 7. 00 7. 01 8. 00 8. 01 10. 00 10. 00 11. 01 11. 00 11. 01 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 11. 01 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 0
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
30. 00	O3000 ADULTS & PEDIATRICS	2, 617	0	8, 850	0	2, 617	30.00
42. 00	04200 SUBPROVI DER	0				0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	ł .	1	,	0	44.00
46. 00	04600 OTHER LONG TERM CARE	0	15, 685	0	17, 508	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	5, 384	0	0	50.00
53. 00	05300 ANESTHESI OLOGY			1		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	•	3, 631		ő	54.00
57.00	05700 CT SCAN	0	0	0		0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	O	0	0	58. 00
60.00	06000 LABORATORY	0	0	1, 076		0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0		0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	188 1, 704		0	65. 00 66. 00
66. 01	06601 CARDI AC REHAB	0		1, 704		0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	135		0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	O	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ		Ö	Ö	73.00
76. 00	03020 SLEEP LAB	0	0	o	0	0	76. 00
76. 01	03950 PAIN CLINIC / SERVICE	0	0	O	0	0	76. 01
76. 02		0	0	0	0	0	76. 02
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	1 0	Ι ο	5, 908	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0		3, 700	0	0	88. 01
90.00	09000 CLI NI C	0	0	600	0	0	90.00
91. 00	09100 EMERGENCY	0	0	5, 541	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	O4040   FAMILY PRACTICE   SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>	0	0	93.00
113 00	11300 INTEREST EXPENSE						113.00
118.00	l l	2, 617	15, 685	38, 722	21, 268	2, 617	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	19201 MIDWEST MEDICAL CLINIC   07950 OTHER NONREIMBURSABLE						192. 01 194. 00
	07951 ASSISTED LIVING UNITS	0	0	i o	19, 152		194.00
	07952 ADULT DAY CARE	0	0	ď	1, 550		194. 02
194. 03	07953 GRANT FUNDED PROGRAMS	0	0	<u> </u> 0	0	0	194. 03

Health Financial Systems	MI DWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 14-1302	
		From 10/01/2022

				Т	o 09/30/2023	Date/Time Pre 2/23/2024 11:	
	Cost Center Description	LAUNDRY &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-	DI ETARY	
	·	LINEN SERVICE	LINEN	(SQUARE FT)	SCC	(PATI ENT	
		(PATI ENT	SERVI CE-SCC		(SQUARE FT	DAYS)	
		DAYS)	(PATIENT DAYS		SCC)		
			SCC)				
		8. 00	8. 01	9. 00	9. 01	10.00	
194. 04 0	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,	125, 627	33, 876	412, 750	143, 079	892, 613	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	48. 004203	2. 159770	10. 626931	3. 409078	341. 082537	203.00
204.00	Cost to be allocated (per Wkst. B,	19, 744	23	19, 100	42	201, 372	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	7. 544517	0. 001466	0. 491761	0. 001001	76. 947650	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	ALLOCATION - STATISTICAL BASIS	WITDWEST WEDIC			Peri od:	Worksheet B-1	
					From 10/01/2022 Fo 09/30/2023	Date/Time Pre 2/23/2024 11:	pared: 09 am
	Cost Center Description	DI ETARY-SCC (PATI ENT DAYS SCC)	CAFETERI A (FTE)	(FTE'S -SCC)	ADMINISTRATIO N (HOURS OF	CENTRAL SERVI CE & SUPPLY (COSTED	
		10. 01	11. 00	11. 01	SERVI CE) 13. 00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS						
11. 01 13. 00 14. 00 15. 00 16. 00	01001 DI ETARY-SCC 01100 CAFETERI A	24, 474 0 0 0 0 0			0 0 2, 959 0 0 0 0	1, 867, 451 0 7, 695 0	15. 00 16. 00
30. 00 42. 00 44. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 04200 SUBPROVIDER	0 0 0 0 15, 685	0 0		1, 650 0 0 0 0	62, 954 0 0	30. 00 42. 00 44. 00
	ANCILLARY SERVICE COST CENTERS	10,000		<b>'</b>	5		
	05000 OPERATING ROOM	0	0	1	645	223, 562	•
53. 00 54. 00	I I	0	0			26, 438 41 917	53. 00 54. 00
57. 00	I I	O	0	1		0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
60.00		0	0		0	0	
64.00		0	0		0		64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0		65. 00 66. 00
66. 01		0	0		0	0	1
67. 00	I I	0	0		0	5, 224	
68.00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	0	0		0	2, 015 0	1
71.00			0		0 0	1, 079, 334	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	1
73.00	1 1	0	0		0	378	1
76. 00 76. 01	03020   SLEEP LAB   03950   PAIN CLINIC / SERVICE	0	0			0	
	03530 SNF PHYSICAL THERAPY - SCC THERAPY	O	0	1	o o	0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0	1	0 0	81, 695 25, 621	1
	09000 CLINIC		0			77, 353	1
	09100 EMERGENCY	0	0		664		91.00
92.00			_			_	92.00
93. 00	04040 FAMILY PRACTICE SPECIAL PURPOSE COST CENTERS	0	0	)  (	0	0	93.00
113. 00	0 11300   INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15, 685	0	) (	2, 959	1, 867, 451	118. 00
400.0	NONREI MBURSABLE COST CENTERS						
	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 019200 PHYSICIANS' PRIVATE OFFICES	0	0	1			190. 00 192. 00
	1 19201 MI DWEST MEDICAL CLINIC		0				192.00
194.00	07950 OTHER NONREIMBURSABLE	0	0		0	0	194. 00
	107951 ASSISTED LIVING UNITS	8, 789	0				194. 01
	2 07952 ADULT DAY CARE 3 07953 GRANT FUNDED PROGRAMS	0	0		0 0		194. 02 194. 03
		, 91			<u>,                                     </u>		

Health Financial Systems	MIDWEST MEDIC	AL CENTER		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
			[	From 10/01/2022		
			-	To 09/30/2023	Date/Time Pre	pared:
					2/23/2024 11:	09 am
Cost Center Description	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	NURSI NG	CENTRAL	
	(PATIENT DAYS	(FTE)	(FTE'S -SCC)	ADMI NI STRATI O	SERVICE &	
	SCC)			N	SUPPLY	
				(HOURS OF	(COSTED	

						2/23/2024 11:	<u>09 am</u>
	Cost Center Description	DI ETARY-SCC	CAFETERI A	CAFETERI A-SCC	NURSI NG	CENTRAL	
		(PATIENT DAYS	(FTE)	(FTE'S -SCC)	ADMI NI STRATI O	SERVICE &	
		SCC)			N	SUPPLY	
					(HOURS OF	(COSTED	
					SERVICE)	REQUIS.)	
		10. 01	11. 00	11. 01	13. 00	14.00	
194.040	07954 IDLE SPACE	0	0	0	0	0	194. 04
194.050	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,	696, 469	0	0	599, 116	242, 895	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	28. 457506	0. 000000	0. 000000	202. 472457	0. 130068	203. 00
204.00	Cost to be allocated (per Wkst. B,	165	0	0	14, 744	37, 122	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 006742	0. 000000	0.000000	4. 982764	0. 019878	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MI DWEST MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-1302

1.03   00100 NEW CAP REL COSTS-2007 NOB						2/23/2024 11	
DIAMON   STONE PROTECTION   TOTAL CONTINUES		Cost Center Description					
SPATEAL SERVICE COST CENTERS   15.00   10.00							
			CHARGES)		,		
SPECIAL SERVICE DOST CRISTERS   15.00   10.00   19.00					SPENT)		
CARRIENT SERVICE COST CENTERS   1.00   DOTOID NEW CAP REL COSTS-BLIDG & FIXT   1.00   DOTOID NEW CAP REL COSTS-BURDE FOUR PREVIOUS   1.00   DOTOID NEW CAP REL COSTS-WARLE FOUR PREVIO							
1.00			15. 00	16. 00	19. 00		
1.01   00103   NEW CAP PEL COSTS-ALU BLICK 1.02   00102   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.03   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.04   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW CAP PEL COSTS-2007   NEW PER 1.02 1.05   00103   NEW PER	1 00						1 00
1.0.2 DOTOO) MAY CAP PIL COSTS-2007 MGB							
1.03   00103   NEW CAP REL COSTS-2007 WOB   2.00							1.02
2.01   0.0001   INEW CAP PEL COSTS-WINELE BUILP NEW HO 0.00400   THE PRINTING PERMITHENT 5.01   0.00700   ADM ITTIN 0.0001   1.00	1.03	00103 NEW CAP REL COSTS-2007 MOB					1.03
4.00   0.0400   IMPLOYEE BERNETTS DEPARTMENT    4.00   5.01   0.0570   0.							2.00
5.01   0.0570   JANUETTING   5.00   5.00   0.0580   USEPITAL BILLING   5.00   0.000   USEPITAL BILLING   5.00   0.000   USEPITAL BILLING   5.00   0.000   USEPITAL BILLING   5.00   0.000   USEPITAL BISTRY CE   5.00   0.000   0.000   USEPITAL BISTRY CE   5.00   0.000   0.000   0.000   USEPITAL BISTRY CE   5.000   0.000		1 1					1
5.02 00590 INFORMATION TECHNOLOGY 5.03 00590 INFORMATION TECHNOLOGY 5.04 00500 OTHER ABIM INSTRATIVE AND GENERAL 5.06 0.00 00500 OTHER ABIM INSTRATIVE AND GENERAL 5.07 0.00 00500 OTHER ABIM INSTRATIVE AND GENERAL 6.00 00500 ORD ABIT ON OF PLANT 7.00 005000 ORD ABIT ON							
5.03 (00500) MOSPITAL BILLING 6.00 (00500) MAINTEANNEL & REPAIRS 6.00 (00500) MAINTEANNEL & REPAIRS 7.00 (00700) OPERATION OF PENANCE 8.00 (00800) LAMINDRY & LINEN SERVICE 8.00 (00800) LAMINDRY & LINEN SERVICE SCC 9.00 (00900) MOSERCEPING 9.01 (00900) MOSERCEPING SCC 9.00 (009							5. 02
0.000   0.000   DETAIN TO PLANT							5. 03
0.0700   OPERATION OF PLANT SCC   7.00   TOTO   OPERATION OF PLANT SCC   8.00   OBBOOL AUMBRY & LINEN SERVICE SCC   8.00   OBBOOL AUMBRY & LINEN SERVICE SCC   8.00   OBBOOL AUMBRY & LINEN SERVICE SCC   8.00   OBBOOL AUMBRY & LINEN SERVICE SCC   8.00   OBBOOL AUMBRY & LINEN SERVICE SCC   9.00   OBBOOL AUMBRY & LINEN SERVICE & SUPPLY   11.00   OBBOOL AFFERN A   9.00   OBBOOL AFF		1 1					5. 04
7. 01 0.0701 (OPERATION OF PLANT-SCC 8.00 0.0800 (ALMORY & LI NEN SERVICE SCC 8.00 0.0900) (ONDISEKEPIN & LI NEN SERVICE SCC 8.00 0.0900) (ONDISEKEPIN & LI NEN SERVICE SCC 9.00 0.0900) (ONDISEKEPIN & LI NEN SERVICE SCC 9.00 0.0900) (ONDISEKEPIN & LI NEN SERVICE SCC 9.00 0.0000) (ONDISEKEPIN & LI NEN SERVICE SCC 9.00 0.0000) (ONDISEKEPIN & LI NEN SERVICE SCC 9.00 0.0000) (ONDISEKEPIN & LI NEN SERVICE SCC 9.0000)  (ONDISEKEPIN & LI NEN SERVICE SCS 9.00000) (ONDISEKEPIN & LI NEN SERVICE SCS 9.00000) (ONDISEKEPIN & LI NEN SERVICE SCS 9.000000) (ONDISEKEPIN & LI NEN SERVICE SCS 9.000000) (ONDISEKEPIN & LI NEN SERVICE SCS 9.00000000) (ONDISEKEPIN & LI NEN SERVICE SCS 9.000000000000000000000000000000000000							6.00
8.00		1 1					
8.01   0.0801   LAUNDRY & LI NEN SERVICE-SCC   9.00   0.0900   0.0900   0.0800   0		1 1					
9.00   00900   HOUSEKEEP ING   9.00   10.00   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.00		1 1					8. 01
10.00   1000   DI ETARY   10.00   10.00   11.00   10.00   11.00   10.00   10.00   10.00   11.00   10.00   11.00   10.00   11							9. 00
10.00   10100   DIETRRY-SCC     10.00   11.00   11.00   CAFETERIA     .00   CAFETERIA     11.00   CAFETERIA     11.00   CAFETERIA   11.00   CAFETERIA     11.00   CAFETERIA     11.00   CAFETERIA   11.00   CAFETERIA     11.00   CAFETERIA     11.00   CAFETERIA   11.00   CAFETERIA     11.00   CAFETERIA     11.00   CAFETERIA   11.00   CAFETERIA   11.00   CAFETERIA   11.00   CAFETERIA   11.00   CAFETERIA   11.00   CAFETERIA   CAFETERIA   CAFETERIA   CAFETERIA   CAFETERIA   CAFETERIA   CAFETERIA   CAFETERIA   CAFETE		1 1					9. 01
11.00   01100   CAFETERI A SCC							
11.01   01101   CAFETERIA-SCC     11.01   13.00   13.00   01300   MISRIS MADMIN STRATION     13.00   13.00   01300   MISRIS MADMIN STRATION     14.00   14.00   14.00   15.0							•
13. 00   01300   NURSI NG ADMINI STRATI ON   14. 00   1100   CENTRAL SERVICE & SUPPLY   15. 00   01500   PHARMACY   15. 00   01500   PHARMACY   15. 00   01500   PHARMACY   16. 00   1600   MEDI CAL RECORDS & LIBRARY   0   42. 857. 849   10   10   17. 00							
15. 00   01500   PHARMACY   3,550,175   0   16. 00   109		1 1					13.00
16. 00   01-000   NEDICAL RECORDS & LIBRARY   0   42, 857, 849   0   100   199. 00	14.00	1 1					14.00
19. 00   01900   NOMPHYSICIAN   ANESTHETISTS   0   0   0   0   0   0   0   0   0		1 1					15. 00
INPATI ENT ROUTINE SERVICE COST CENTERS   0		1 1					
30. 00   03000   ADULTS & PEDIATRICS   0   3,882,439   0   42. 00   420.0   420.0   SUBPROVIDER   0   0   0   0   0   42. 00   420.0   420.0   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   540.00   55	19.00		0		100		19.00
42.00   04200   SUBEROVI DER   0 0 0 0   42.00	30.00		0	3, 882, 439	0		30.00
A6. 00   0.0600  OTHER LONG TERN CARE			0				42.00
ANCILLARY SERVICE COST CENTERS		1 1	0				44.00
50.00   050000   05000   05000   05000   05000   05000   050000   050000   05000   05000   050000   050000   050000   050000   050000   0500	46. 00		0	0	0		46.00
53.00   05300   ADSTONE STHESI DLOGY   53.00   54.00   54.00   54.00   54.00   56.00	50.00		0	6 389 235	0		50.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   0   7,883,494   0   54.00   57.00   57.00   57.00   CT SCAN   0   0   0   0   0   0   0   57.00   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   0   0   0   0   0   0   0   0			0				53.00
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0			0				54.00
60.00   66000   LABORATORY   0   4, 762, 694   0   66.00   64.00   064000   INTRAVENDUS THERAPY   0   942, 417   0   66.00   65.00   06500   RESPI RATORY THERAPY   0   66.698   0   65.00   66.00   06600   RYSI CAL THERAPY   0   4, 438, 532   0   66.00   66.01   06600   CARDIA CREHAB   0   241, 760   0   66.00   67.00   06700   05CUIPATI ONAL THERAPY   0   396, 117   0   67.00   68.00   06800   SPEECH PATHOLOGY   0   250, 138   0   67.00   69.00   06900   ELECTROCARDI OLOGY   0   250, 138   0   0   69.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   2, 188, 525   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74.00   03020   SLEEP LAB   0   0   0   0   76.00   03020   SLEEP LAB   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   76.02   00100   00000   0   76.03   000000   00000   000000   000000   000000			0	1	1		57.00
64.00   06400   INTRAVENOUS THERAPY   0   942, 417   0   66.05   65.00   06500   RESPI RATORY THERAPY   0   66.698   0   65.00   66.00   06600   PHYSI CAL THERAPY   0   4, 438, 532   0   66.00   66.01   06601   CARDI AC REHAB   0   241, 760   0   66.01   67.00   06700   OCCUPATI ONAL THERAPY   0   396, 117   0   67.00   68.00   06800   SPEECH PATHOLOGY   0   250, 138   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0   250, 138   0   69.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   2, 188, 525   0   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   2, 188, 525   0   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   75.00   03020   SLEEP LAB   0   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNF PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03580   RIRAL HEALTH CLINIC   0   0   0   0   76.03   04040   FAMI LY PRACTI CE   0   0   0   0   77.00   09000   01100   EMERGENCY   0   3, 385, 992   0   0   77.00   09000   01100   EMERGENCY   0   3, 385, 992   0   77.00   09000   011000   01100   011000   011000   01100		1 1	0	1			58.00
65.00   06500   RESPIRATORY THERAPY   0   66.08   0   66.00   66.00   06600   PHYSI CAL THERAPY   0   4.488,532   0   66.00   66.01   06601   CARDI AC REHAB   0   241,760   0   66.01   67.00   06700   OCCUPATI ONAL THERAPY   0   396,117   0   67.00   68.00   06800   SPEECH PATHOLOGY   0   250,138   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   2,188,525   0   0   0   72.00   072.00   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   3,550,175   3,550,175   0   0   0   76.01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76.02   03530   SNP PHYSI CAL THERAPY - SCC THERAPY   0   0   0   0   76.02   03530   SNP PHYSI CAL THERAPY - SCC THERAPY   0   0   0   76.02   036800   RURAL HEALTH CLINIC   0   2,192,669   0   88.01   08800   RURAL HEALTH CLINIC   0   2,192,669   0   88.01   08800   RURAL HEALTH CLINIC   0   2,192,669   0   88.01   08800   RURAL HEALTH CLINIC   0   2,192,669   0   90.00   09000   CLINIC   0   0,33,385,992   0   91.00   09100   EMERGENCY   0   0   0   92.00   9200   08SERVATION BEDS (NON-DISTINCT PART)   93.00   04000   EMERGENCY   0   0   0   94.00   09100   EMERGENCY   0   0   0   95.00   09100   EMERGENCY   0   0   0   97.00   09100   000   000   000   000   97.00   000   000   000   000   000   97.00   000   000   000   000   000   97.00   000   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   000   000   97.00   000   000   00		1 1	0		-		
66. 00   06600   PHYSICAL THERAPY   0   4,438,532   0   66. 00   066000   06600   066000   066000   066000   066000   066000		1 1	0				
67. 00   06700   06700   0CCUPATI ONAL THERAPY   0   390, 117   0   68. 00   06800   SPEECH PATHOLOGY   0   0   250, 138   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0		1 1	0				66.00
68.00		1 1	0	241, 760	0		66. 01
69, 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   2, 188, 525   0   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 550, 175   3, 550, 175   0   0   76. 00   03020   SLEEP LAB   0   0   0   0   76. 01   03950   PAIN CLINIC / SERVICE   0   0   0   0   76. 02   03530   SNF PHYSICAL THERAPY - SCC THERAPY   0   0   0   0   0000   0000   0000   0000   0   88. 01   08801   RURAL HEALTH CLINIC   0   2, 192, 669   0   88. 01   08801   RURAL HEALTH CLINIC   0   672, 548   0   89. 00   09000   CLINIC   0   203, 499   0   91. 00   09000   CLINIC   0   0   0   92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   92. 00   93. 00   04040   FAMILY PRACTICE   0   0   0   0   93. 00   04040   FAMILY PRACTICE   0   0   0   91. 13. 00   13000   INTEREST EXPENSE   113. 00   13000   INTEREST EXPENSE   113. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   192. 00   19200   PHYSICIANS' PRIVATE OFFICES   0   0   0   192. 00   19200   PHYSICIANS' PRIVATE OFFICES   0   0   0   194. 01   19201   MI DWEST MEDI CAL CLINIC   0   0   0   194. 01   07950   OTHER NONREI MBURSABLE   0   0   0   194. 01   07950   OTHER NONREI MBURSABLE   0   0   0   194. 01   07950   OTHER NONREI MBURSABLE   0   0   0   194. 01   07951   ASSISTED LIVING UNITS   0   0   197. 00   00   00   0   0   198. 00   00   00   0   199. 00   00   00   0   199. 00   00   00   0   199. 00   00   00   0   199. 00   00   00   0   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   00   00   00   199. 00   0		1 1	0				67.00
71. 00			0	250, 138			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 7330 DRUGS CHARGED TO PATIENTS 3,550,175 0 73. 00 7300 DRUGS CHARGED TO PATIENTS 3,550,175 0 73. 00 76. 00 03020 SLEEP LAB 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 03950 PAIN CLINIC / SERVICE 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0	0 2 199 525	· -		
73. 00		1 1	0	2, 100, 323			72.00
76. 01	73.00	07300 DRUGS CHARGED TO PATIENTS	3, 550, 175	3, 550, 175	0		73.00
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY 0 0 0 0 76. 02  0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 2, 192, 669 0 88. 01  90. 00 09000 CLINIC 0 0 203, 499 0 99. 00  91. 00 09100 EMERGENCY 0 3, 385, 992 0 991. 00  92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92. 00  93. 00 04040 FAMILY PRACTICE 0 0 0 0 0 93. 00  SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 550, 175 42, 857, 849 100  118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19200 PHYSI CIANS' PRI VATE OFFICES 0 0 0 0 192. 00  192. 01 19201 MI DWEST MEDI CAL CLINIC 0 0 0 0 194. 00  194. 00 07950 OTHER NONREI MBURSABLE 0 0 0 0 194. 01  194. 01 07951 ASSISTED LIVING UNITS 0 0 0 194. 00  194. 01 07951 ASSISTED LIVING UNITS			0	0			76. 00
Second   S			0				76. 01
88. 00	76.02		0	0	0		→ <sup>76.02</sup>
88. 01	88 NN	08800 RURAL HEALTH CLINIC	0	2 192 669	n		88 00
90. 00			0				88. 01
92. 00		09000 CLI NI C	0				90.00
93. 00			0	3, 385, 992	0		91.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   SUBTOTALS (SUM OF LINES 1 through 117)   3,550,175   42,857,849   100   118.00   NONREI MBURSABLE COST CENTERS   100   118.			•				92.00
113. 00	93.00		0	0	0		93.00
118. 00	113. 00						113.00
NONREI MBURSABLE COST CENTERS   190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   192.00   192.00   192.00   192.00   192.00   192.00   192.01   192.01   192.01   192.01   MI DWEST MEDI CAL CLI NI C   0   0   0   0   192.01   194.01   194.01   194.01   194.01   197.01   194.01   197.01   194.01			3, 550, 175	42, 857, 849	100		118.00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       192. 00         192. 01   19201   MI DWEST MEDI CAL CLI NI C       0       0       0       192. 01         194. 00   07950   OTHER NONREI MBURSABLE       0       0       0       194. 00         194. 01   07951   ASSI STED LI VI NG UNI TS       0       0       0       194. 01		NONREI MBURSABLE COST CENTERS					
192. 01   19201   MI DWEST MEDI CAL CLI NI C 0 0 0 192. 01 194. 00 07950   OTHER NONREI MBURSABLE 0 0 0 194. 00 194. 01 07951   ASSI STED LI VI NG UNI TS 0 0 0 194. 01			0	1	1		190.00
194. 00   07950   OTHER NONREI MBURSABLE 0 0 0 194. 00 194. 00 194. 01 07951   ASSI STED LI VI NG UNI TS 0 0 194. 01		1 1	0	0	1		192.00
194. 01 07951 ASSISTED LIVING UNITS 0 0 0 194. 01			0		1		
		1 1	0	0	1		194.00
			0	•	-		194. 02
					. '		<u> </u>

Heal th Financial Systems MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302 | Period: From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

				10	0 09/30/2023	Date/lime Prepared: 2/23/2024 11:09 am
	Cost Center Description	PHARMACY (GROSS CHARGES)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES HOSP BI LLI NG)	NONPHYSI CI AN ANESTHETI STS (TI ME SPENT)		
		15. 00	16. 00	19. 00		
	GRANT FUNDED PROGRAMS	0	0	0		194. 03
194. 04 07954		0	0	0		194. 04
	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)	84, 673	462, 978	800, 865		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 023850	0. 010803	8, 008. 650000		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	42, 586	42, 265	10, 635		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 011995	0. 000986	106. 350000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1302	Peri od: Worksheet C From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

				-	To 09/30/2023	Date/Time Pre 2/23/2024 11:	
			Title	: XVIII	Hospi tal	Cost	<u> </u>
			11.11		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, and the second	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 315, 003		4, 315, 003	0	4, 315, 003	30.00
42.00	04200 SUBPROVI DER	0			0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	29, 756		29, 750	0	29, 756	44.00
46.00	04600 OTHER LONG TERM CARE	3, 433, 962		3, 433, 962	0	3, 433, 962	46. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 528, 107		2, 528, 10	7 0	2, 528, 107	
53.00	05300 ANESTHESI OLOGY	887, 485		887, 485		887, 485	
	05400 RADI OLOGY-DI AGNOSTI C	2, 288, 908		2, 288, 908	0	2, 288, 908	
57. 00	05700 CT SCAN	0			0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			1	0	
60.00	06000 LABORATORY	1, 687, 031		1, 687, 03°		1, 687, 031	1
64.00	06400 I NTRAVENOUS THERAPY	84, 700		84, 700		84, 700	
	06500 RESPI RATORY THERAPY	94, 142	0	, .,		94, 142	
66.00	06600 PHYSI CAL THERAPY	3, 084, 232	0	3, 084, 232	1	3, 084, 232	
66. 01	06601 CARDI AC REHAB	262, 163	0	262, 163		262, 163	
	06700 OCCUPATI ONAL THERAPY	270, 550	0	270, 550		270, 550	
68.00	06800 SPEECH PATHOLOGY	149, 403	0	149, 403		149, 403	
	06900 ELECTROCARDI OLOGY	0		(	۲ <sub>ا</sub> ۲	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 426, 588		1, 426, 588	9	1, 426, 588	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		4 444 7/		0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 SLEEP LAB	1, 111, 764		1, 111, 76	t o	1, 111, 764	
		0				0	
76. 01	03950 PAIN CLINIC / SERVICE 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0				0	1
76. 02		0			<u>)                                    </u>	U	76.02
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	3, 141, 206		3, 141, 200	0	3, 141, 206	88. 00
	08801 RURAL HEALTH CLINIC II	894, 740		894, 740		3, 141, 200 894, 740	1
	09000 CLINIC	890, 860		890, 860		890, 860	1
	09100 EMERGENCY	3, 207, 834		3, 207, 834		3, 207, 834	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	421, 126		421, 120		421, 126	1
	04040 FAMILY PRACTICE	421, 120		421, 120		421, 120	1
73.00	SPECIAL PURPOSE COST CENTERS			`	91 91	0	75.00
113 00	11300   INTEREST EXPENSE						113.00
200.00		30, 209, 560	0	30, 209, 560		30, 209, 560	
201.00		421, 126		421, 120		421, 126	
202.00		29, 788, 434		•			
	( )		ı		٠, ۳		1

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1302	Period: Worksheet C From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared

			Т	o 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Title	XVIII	Hospi tal	Cost	07 diii
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
•	'	•	+ col. 7)	Rati o	I npati ent	
			,		Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 431, 683		3, 431, 683			30.00
42. 00   04200   SUBPROVI DER	O		l c	l l		42.00
44.00 04400 SKILLED NURSING FACILITY	O					44.00
46.00 04600 OTHER LONG TERM CARE	4, 237, 764		4, 237, 764			46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	800, 739	5, 588, 496	6, 389, 235	0. 395682	0.000000	50.00
53. 00   05300   ANESTHESI OLOGY	24, 373	1, 386, 545	1, 410, 918	0. 629012	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	223, 308	7, 660, 186	7, 883, 494	0. 290342	0.000000	54.00
57. 00   05700   CT   SCAN	O	0	l c	0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0	l c	0.000000	0.000000	58.00
60. 00   06000   LABORATORY	273, 537	4, 489, 157	4, 762, 694	0. 354218	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	8, 517	933, 900	942, 417	0. 089875	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	23, 786	42, 913	66, 699	1. 411445	0.000000	65.00
66. 00   06600 PHYSI CAL THERAPY	737, 880	3, 700, 651	4, 438, 531	0. 694877	0.000000	66.00
66. 01   06601   CARDI AC   REHAB	O	241, 760	241, 760	1. 084394	0.000000	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	232, 257	163, 860	396, 117	0. 683005	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	114, 767	135, 371	250, 138	0. 597282	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0	C		0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	370, 207	1, 818, 318	2, 188, 525	0. 651849	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	C	0. 000000	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	871, 266	2, 678, 909	3, 550, 175	0. 313158	0.000000	73.00
76. 00 03020 SLEEP LAB	O	0	C	0. 000000	0.000000	76.00
76.01 03950 PAIN CLINIC / SERVICE	o	0	l c	0. 000000	0.000000	76. 01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	O	0	[ c	0.000000	0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	2, 192, 669	2, 192, 669			88. 00
88.01 08801 RURAL HEALTH CLINIC II	O	672, 548	672, 548			88. 01
90. 00   09000   CLI NI C	O	203, 499	203, 499	4. 377712	0.000000	90.00
91. 00 09100 EMERGENCY	10, 000	3, 375, 991	3, 385, 991	0. 947384	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 192	448, 564	450, 756	0. 934266	0.000000	92.00
93. 00   04040   FAMILY   PRACTICE	O	0	C	0. 000000	0.000000	93.00
SPECIAL PURPOSE COST CENTERS						]
113. 00 11300   NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	11, 362, 276	35, 733, 337	47, 095, 613			200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	11, 362, 276	35, 733, 337	47, 095, 613			202. 00
	'					-

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 am

				2/23/2024 11:09 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
42. 00   04200   SUBPROVI DER				42.00
44.00   04400   SKILLED NURSING FACILITY				44.00
46.00 O4600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 395682			50.00
53. 00   05300   ANESTHESI OLOGY	0. 629012			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 290342			54.00
57. 00  05700   CT   SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00   06000   LABORATORY	0. 354218			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 089875			64.00
65. 00 06500 RESPIRATORY THERAPY	1. 411445			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 694877			66.00
66. 01   06601   CARDI AC   REHAB	1. 084394			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 683005			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 597282			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 651849			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313158			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
90. 00  09000   CLI NI C	4. 377712			90.00
91. 00 09100 EMERGENCY	0. 947384			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 934266			92.00
93. 00   04040   FAMILY PRACTICE	0. 000000			93.00
SPECIAL PURPOSE COST CENTERS	·			
113. 00 11300   NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems	MIDWEST MEDICAL	CENTER		In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN:	14-1302	From 10/01/2022	Worksheet C Part I Date/Time Prepared:

					To 09/30/2023	Date/Time Pre 2/23/2024 11:	epared: 09 am
			Ti tl	e XIX	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 315, 003		4, 315, 00		4, 315, 003	
	04200 SUBPROVI DER	0		l .	0	0	
	04400 SKILLED NURSING FACILITY	29, 756		29, 75		29, 756	1
46. 00	04600 OTHER LONG TERM CARE	3, 433, 962		3, 433, 96	2 0	3, 433, 962	46. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	2, 528, 107		2, 528, 10		2, 528, 107	
53. 00	05300 ANESTHESI OLOGY	887, 485		887, 48		887, 485	
	05400 RADI OLOGY-DI AGNOSTI C	2, 288, 908		2, 288, 90	8 0	2, 288, 908	
57.00	05700 CT SCAN	0			0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		l .	0	0	
60.00	06000 LABORATORY	1, 687, 031		1, 687, 03		1, 687, 031	1
64.00	06400 I NTRAVENOUS THERAPY	84, 700		84, 70		84, 700	
65.00	06500 RESPI RATORY THERAPY	94, 142	0	,		94, 142	
66.00	06600 PHYSI CAL THERAPY	3, 084, 232	0	3, 084, 23		3, 084, 232	1
66. 01	06601 CARDI AC REHAB	262, 163	0	262, 16		262, 163	
	06700 OCCUPATI ONAL THERAPY	270, 550	0	270, 55		270, 550	
68.00	06800 SPEECH PATHOLOGY	149, 403	U	149, 40		149, 403	
	06900 ELECTROCARDI OLOGY	1 40/ 500			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 426, 588		1, 426, 58	0	1, 426, 588	
	07200 I MPL. DEV. CHARGED TO PATIENTS	1 111 7/4		1 111 7/	0	1 111 7/4	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 111, 764		1, 111, 76	4 0	1, 111, 764	
	03020 SLEEP LAB	0				0	1 . 0. 00
76. 01	03950 PAIN CLINIC / SERVICE	0				0	1
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY OUTPATIENT SERVICE COST CENTERS	0			J U	0	76.02
88. 00	08800 RURAL HEALTH CLINIC	3, 141, 206		3, 141, 20	6 0	3, 141, 206	88. 00
	08801 RURAL HEALTH CLINIC	894, 740		894, 74		3, 141, 200 894, 740	
	109000 CLINIC	890, 860		890, 86		890, 860	
	09100 EMERGENCY	3, 207, 834		3, 207, 83		3, 207, 834	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	421, 126		421, 12		421, 126	
	04040 FAMILY PRACTICE	421, 120				421, 120	1
73.00	SPECIAL PURPOSE COST CENTERS	U			J <sub> </sub>	U	73.00
113 00	11300 I NTEREST EXPENSE						113.00
200.00	1	30, 209, 560	0	30, 209, 56		30, 209, 560	
201.00		421, 126		421, 12		421, 126	
202.00		29, 788, 434	0	•			
202.00	1.010. (000 111011 4011 0110)	27,700,404	1	27,700,40	., 9	27, 700, 404	1-32.00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

					0 09/30/2023	2/23/2024 11:	pared: 09 am
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	'	'	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 431, 683		3, 431, 683	3		30.00
42.00	04200 SUBPROVI DER	o		C			42.00
44.00	04400 SKILLED NURSING FACILITY	o		C			44.00
46.00	04600 OTHER LONG TERM CARE	4, 237, 764		4, 237, 764			46.00
	ANCILLARY SERVICE COST CENTERS				•	•	
50.00	05000 OPERATING ROOM	800, 739	5, 588, 496	6, 389, 235	0. 395682	0.000000	50.00
53.00	05300 ANESTHESI OLOGY	24, 373	1, 386, 545	1, 410, 918	0. 629012	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	223, 308	7, 660, 186	7, 883, 494	0. 290342	0.000000	54.00
57.00	05700 CT SCAN	0	0	C	0. 000000	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	C	0.000000	0.000000	58. 00
60.00	06000 LABORATORY	273, 537	4, 489, 157	4, 762, 694	0. 354218	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	8, 517	933, 900	942, 417	0. 089875	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	23, 786	42, 913	66, 699	1. 411445	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	737, 880	3, 700, 651	4, 438, 531	0. 694877	0.000000	66.00
66. 01	06601 CARDI AC REHAB	o	241, 760	241, 760	1. 084394	0.000000	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	232, 257	163, 860	396, 117	0. 683005	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	114, 767	135, 371	250, 138	0. 597282	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	o	0			0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	370, 207	1, 818, 318	2, 188, 525	0. 651849	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0	C	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	871, 266	2, 678, 909	3, 550, 175	0. 313158	0.000000	73.00
76.00	03020 SLEEP LAB	o	0	C	0.000000	0.000000	76.00
76. 01	03950 PAIN CLINIC / SERVICE	o	0		0. 000000	0.000000	76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	o	0	l c	0. 000000	0.000000	76. 02
	OUTPATIENT SERVICE COST CENTERS				*		
88.00	08800 RURAL HEALTH CLINIC	0	2, 192, 669	2, 192, 669	1. 432595	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	o	672, 548	672, 548	1. 330373	0.000000	88. 01
90.00	09000 CLI NI C	o	203, 499	203, 499	4. 377712	0.000000	90.00
91.00	09100 EMERGENCY	10, 000	3, 375, 991	3, 385, 991	0. 947384	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 192	448, 564	450, 756	0. 934266	0.000000	92.00
93.00	04040 FAMILY PRACTICE	o	0	C	0.000000	0.000000	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300   NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	11, 362, 276	35, 733, 337	47, 095, 613	3		200.00
201.00	Less Observation Beds						201.00
202.00		11, 362, 276	35, 733, 337	47, 095, 613	3		202.00
		. '		•	•	•	•

Health Financial Systems	MI DWEST MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 am

				10 07/30/2023	2/23/2024 11:	
			Title XIX	Hospi tal	Cost	
Cost Center Description	PP	S Inpatient				
		Ratio				
		11. 00				
INPATIENT ROUTINE SERVICE COST	CENTERS					
30. 00 03000 ADULTS & PEDIATRICS						30.00
42. 00   04200   SUBPROVI DER						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 ANESTHESI OLOGY		0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 000000				54.00
57.00 05700 CT SCAN		0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE I MAGI	NG (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	` '	0. 000000				60.00
64.00 06400 INTRAVENOUS THERAPY		0. 000000				64.00
65. 00 06500 RESPIRATORY THERAPY	•	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	•	0. 000000				66.00
66. 01 06601 CARDI AC REHAB		0. 000000				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY		0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PA	TIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENT	S	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 - S	CC THERAPY	0. 000000				76. 02
OUTPATIENT SERVICE COST CENTER	RS	·				
88.00 08800 RURAL HEALTH CLINIC		0. 000000				88. 00
88.01 08801 RURAL HEALTH CLINIC II		0. 000000				88. 01
90. 00  09000 CLI NI C		0. 000000				90.00
91.00 09100 EMERGENCY		0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DI	STINCT PART)	0. 000000				92.00
93.00 04040 FAMILY PRACTICE		0. 000000				93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instruction	ns)					200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)						202.00

Health Financial	Systems				MIDWEST MEDIC	AL CENTER			In Lieu	of Form C	MS-2552-10
APPORTI ONMENT OF	I NPATI ENT	ANCI LLARY	SERVI CE	CAPI TAL	COSTS	Provi der	CCN	: 14-1302	od: 10/01/2022 09/30/2023		Prepared:

				From 10/01/2022 To 09/30/2023		
		Title	XVIII	Hospi tal	Cost	O7 alli
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00 05000 OPERATING ROOM	653, 602					50.00
53. 00   05300   ANESTHESI OLOGY	26, 857		•			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	488, 193	7, 883, 494			5, 614	54.00
57. 00   05700   CT   SCAN	0	0	0. 000000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 000000		0	58. 00
60. 00   06000   LABORATORY	107, 344	4, 762, 694				60.00
64. 00 06400 I NTRAVENOUS THERAPY	3, 413	942, 417			0	64.00
65. 00 06500 RESPI RATORY THERAPY	16, 790				2, 555	65.00
66. 00 06600 PHYSI CAL THERAPY	289, 144	4, 438, 531				66. 00
66. 01   06601   CARDI AC   REHAB	28, 583				0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	23, 193					67.00
68. 00 06800 SPEECH PATHOLOGY	2, 445	250, 138				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 000000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42, 246	2, 188, 525				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 000000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 251	3, 550, 175			5, 322	73.00
76. 00   03020   SLEEP LAB	0	0	0. 000000		0	76. 00
76. 01   03950   PAIN CLINIC / SERVICE	0	0	0. 000000		0	76. 01
76. 02 03530 SNF PHYSI CAL THERAPY - SCC THERAPY	0	0	0. 000000	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS	050.400	0 400 //0		.1		
88. 00 08800 RURAL HEALTH CLINIC	352, 199				-	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	19, 131	672, 548	•		0	88. 01
90. 00   09000   CLI NI C	75, 820				0	90.00
91. 00   09100   EMERGENCY	353, 362		•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	76, 018				0	92.00
93. 00 04040 FAMILY PRACTICE	0	0	0.00000		0	93.00
200.00   Total (lines 50 through 199)	2, 620, 591	39, 426, 166	l	1, 431, 818	81, 796	200.00

Health Financial Systems	MIDWEST MEDICAL	CENTER	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1302		Worksheet D
THROUGH COSTS			From 10/01/2022	Part IV

THROUGH COSTS 09/30/2023 Date/Time Prepared: To 2/23/2024 11:09 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Program Anesthetist Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 50.00 0 0 0 800, 865 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 05700 CT SCAN 0 0 57.00 00000000000000000 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 58.00 0 60.00 06000 LABORATORY 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 Ω 66.00 66.00 0 66.01 06601 CARDI AC REHAB 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 76.00 03020 SLEEP LAB 0 0 76.00 76. 01 03950 PAIN CLINIC / SERVICE 0 0 o 0 76.01 03530 SNF PHYSICAL THERAPY - SCC THERAPY 0 0 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 08801 RURAL HEALTH CLINIC II 0 88.01 88. 01 0 0 0 0 0 0 90.00 09000 CLI NI C 0 Ω 90.00 0 91.00 09100 EMERGENCY 91.00 C 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 93. 00 04040 FAMILY PRACTICE 0 0 0 0 0 93.00 0 Total (lines 50 through 199) 800, 865 0 0 0 200.00 200.00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS   Provider CCN: 14-1302	Peri od: Worksheet D From 10/01/2022 Part IV To 09/30/2023 Date/Time Prepared:

THROUGH COSTS			Τ̈́	o 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	6, 389, 235	0.000000	
53. 00   05300   ANESTHESI OLOGY	0	800, 865	C	1, 410, 918	0. 567620	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	7, 883, 494	0.000000	
57. 00   05700   CT   SCAN	0	0	C	0	0.000000	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	0	0.000000	
60. 00   06000   LABORATORY	0	0	C	4, 762, 694	0.000000	
64. 00   06400   I NTRAVENOUS THERAPY	0	0	C	942, 417	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0	C	66, 699	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	C	4, 438, 531	0.000000	
66. 01   06601   CARDI AC   REHAB	0	0	C	241, 760	0.000000	
67. 00   06700   OCCUPATI ONAL THERAPY	0	0	C	396, 117	0.000000	
68.00 06800 SPEECH PATHOLOGY	0	0	C	250, 138	0.000000	
69. 00   06900   ELECTROCARDI OLOGY	0	0	C	0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	2, 188, 525	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	3, 550, 175	0.000000	
76. 00   03020   SLEEP LAB	0	0	C	0	0.000000	
76. 01   03950   PAIN CLINIC / SERVICE	0	0	C	0	0.000000	76. 01
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	C	0	0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0	0	C	2, 192, 669	0.000000	
88. 01   08801   RURAL HEALTH CLINIC II	0	0	C	672, 548	0.000000	
90. 00   09000   CLI NI C	0	0	C	203, 499	0.000000	
91. 00   09100   EMERGENCY	0	0	C	3, 385, 991	0.000000	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	450, 756	0.000000	
93. 00   04040   FAMILY   PRACTICE	0	0	C	0	0.000000	
200.00 Total (lines 50 through 199)	0	800, 865	(	39, 426, 166		200. 00

	Financial Systems	MIDWEST MEDICA	_			u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provi der C		Period: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Pre 2/23/2024 11:	
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	503, 682		0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	16, 047	•	9 0	0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	90, 661		0	0	54.00
57.00	05700 CT SCAN	0. 000000	0		0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 000000	117, 493		0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	107		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	10, 151		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	109, 938		0	0	66.00
66. 01	06601 CARDI AC REHAB	0. 000000	0		0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	28, 289		0	0	
68.00	06800 SPEECH PATHOLOGY	0. 000000	15, 036		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	233, 529		0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	303, 497		0	0	
76.00	03020 SLEEP LAB	0. 000000	0		0 0	0	76.00
76. 01	03950 PAIN CLINIC / SERVICE	0. 000000	0		0	0	76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0. 000000	0		0 0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
90 00	09000 CLINIC	0. 000000	Ω		0 0	0	90 00

0. 000000 0. 000000 0. 000000 0. 000000

0.000000

0. 000000

3, 388

1, 431, 818

0

0

9, 109

91.00 0

0 92.00 0 93.00 0 200.00

0 90.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

93. 00 | 04040 | FAMILY PRACTICE | 200. 00 | Total (lines 50 through 199)

| Peri od: | Worksheet D | From 10/01/2022 | Part V | To | 09/30/2023 | Date/Time | Prepared:

					0 09/30/2023	2/23/2024 11:	pared: 09 am
			Title	XVIII	Hospi tal	Cost	<u> </u>
			<u> </u>	Charges	•	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 395682	0	.,,		0	
	D5300 ANESTHESI OLOGY	0. 629012	0	325, 867		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 290342	0	2, 519, 672	2 0	0	54.00
	05700 CT SCAN	0. 000000	0	(	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	(	0	0	58.00
60.00 0	06000 LABORATORY	0. 354218	0	1, 356, 919		0	60.00
	06400 INTRAVENOUS THERAPY	0. 089875	0	314, 872	0	0	64.00
65.00 0	06500 RESPI RATORY THERAPY	1. 411445	0	16, 139	0	0	65.00
	06600 PHYSI CAL THERAPY	0. 694877	0	1, 625, 864	1 0	0	66.00
	06601 CARDI AC REHAB	1. 084394	0	156, 355	0	0	66. 01
	06700 OCCUPATI ONAL THERAPY	0. 683005	0	41, 244		0	67.00
	06800 SPEECH PATHOLOGY	0. 597282	0	57, 985	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000	0	(	0	0	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 651849	0	393, 357	0	0	71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 313158	0	800, 955	1, 116	0	73.00
76.00 0	3020 SLEEP LAB	0. 000000	0	(	0	0	76.00
76. 01 0	03950 PAIN CLINIC / SERVICE	0. 000000	0	(	0	0	76. 01
	3530 SNF PHYSICAL THERAPY - SCC THERAPY	0. 000000	0	(	0	0	76. 02
	UTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88. 00
	08801 RURAL HEALTH CLINIC II						88. 01
90.00 0	99000 CLI NI C	4. 377712	0	46, 545	0	0	90.00
91.00 0	9100 EMERGENCY	0. 947384	0	1, 047, 492	4, 712	0	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 934266	0	291, 090	0	0	92.00
93.00 0	04040 FAMILY PRACTICE	0. 000000	0	(	0	0	93.00
200.00	Subtotal (see instructions)		0	10, 571, 084	5, 828	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0	10, 571, 084	5, 828	0	202. 00

From 10/01/2022 Par	Worksheet D Part V Date/Time Prepared

					To 09/30/2023	Date/Time Pro 2/23/2024 11	
			Title	XVIII	Hospi tal	Cost	
	·	Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	623, 883					50.00
	05300 ANESTHESI OLOGY	204, 974	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	731, 567	0				54.00
	05700 CT SCAN	0	0				57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
60.00	06000 LABORATORY	480, 645	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	28, 299	0				64.00
65.00	06500 RESPI RATORY THERAPY	22, 779	0				65.00
66. 00	06600 PHYSI CAL THERAPY	1, 129, 775	0				66.00
66. 01	06601 CARDI AC REHAB	169, 550	0				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	28, 170	0				67.00
68. 00	06800 SPEECH PATHOLOGY	34, 633	0				68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	256, 409	0				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	250, 825	349				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
Ī	OUTPATIENT SERVICE COST CENTERS	•	•				
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
	09000 CLI NI C	203, 761	0				90.00
91.00	09100 EMERGENCY	992, 377	4, 464				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	271, 955	0				92.00
	04040 FAMILY PRACTICE	0	0				93.00
200.00	Subtotal (see instructions)	5, 429, 602	4, 813				200.00
201.00	Less PBP Clinic Lab. Services-Program	0	1				201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	5, 429, 602	4, 813				202. 00

		Component	CCN: 14-Z302	10 09/30/2023	Date/lime Pre   2/23/2024 11:	
		Title	XVIII S	wing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 395682	0	(	0	0	50.00
53. 00   05300   ANESTHESI OLOGY	0. 629012	0	(	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 290342	0	(	0	0	54.00
57.00 05700 CT SCAN	0. 000000	0	(	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		o	0	58. 00
60. 00 06000 LABORATORY	0. 354218	0		0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 089875	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	1. 411445	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 694877	0	1 (	0	0	66.00
66. 01 06601 CARDI AC REHAB	1. 084394	0	1 (	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 683005	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 597282	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 651849	0	(	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 313158	0	(	0	0	73.00
76. 00 03020 SLEEP LAB	0. 000000	0		0	Ō	76.00
76. 01 03950 PAIN CLINIC / SERVICE	0. 000000	0		0	o o	76. 01
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0. 000000	0		0	_	76. 02
OUTPATIENT SERVICE COST CENTERS	0.000000			<u>,                                     </u>		70.02
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01   08801 RURAL HEALTH CLINIC II						88. 01
90. 00   09000   CLI NI C	4. 377712	0		0	0	90.00
91. 00 09100 EMERGENCY	0. 947384	0			0	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 934266	0			0	92.00
93. 00   04040   FAMILY   PRACTICE	0. 934200	0			0	93.00
200.00 Subtotal (see instructions)	0.000000	0			-	200.00
201.00   Subtotal (see Histructions) 201.00   Less PBP Clinic Lab. Services-Program		Ü			0	200.00
Only Charges				ا		201.00
202.00 Net Charges (line 200 - line 201)		0	(	o	n	202. 00
17110 201)	1 1	O	1	-1 9	·	1-32.00

Health Financial Systems	MI DWEST MEDI CAI	L CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 14-1302	Peri od: From 10/01/2022	Worksheet D Part V
		Component CCN: 14-Z302		

		Component (	CCN: 14-Z302	To 09/30/2023	Date/Time Prepar 2/23/2024 11:09	red:
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	0			-	0.00
53. 00   05300   ANESTHESI OLOGY	0	0				3.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				4.00
57. 00   05700   CT   SCAN	0	0				7.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				8.00
60. 00   06000   LABORATORY	0	0				60.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0				4.00
65. 00 06500 RESPI RATORY THERAPY	0	0				5.00
66. 00   06600   PHYSI CAL THERAPY	0	0			•	6.00
66. 01   06601   CARDI AC   REHAB	0	0				6. 01
67. 00   06700   OCCUPATI ONAL THERAPY	0	0				7.00
68. 00   06800   SPEECH PATHOLOGY	0	0				8.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				9.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	0	0				71.00
72. 00 07200 I MPL. 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						38. 00
88. 01 08801 RURAL HEALTH CLINIC II						38. 01
90. 00   09000   CLI NI C	0	0				90.00
91. 00   09100   EMERGENCY	0	0				91.00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART) 93.00   04040   FAMILY PRACTICE		0				92.00 93.00
	0	ŭ,				
200.00 Subtotal (see instructions)		0				00.00
201.00 Less PBP Clinic Lab. Services-Program					20	01.00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	0			20	2. 00
202.00   Net charges (Title 200 - Title 201)	١	υĮ	l		J20.	,2.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	MI DWEST MEDI		CN: 14 1202	T <sub>D</sub>	<u> </u>	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WICE UINER PAS	S Provider Co	UN. 14-13UZ		om 10/01/2022		
THROUGH COSTS		Component	CCN: 14-6140	To			
		Title	XVIII	SI	killed Nursing	PPS	<u> </u>
				Ш,	Facility		
Cost Center Description	Non Physician		Nursi ng		Allied Health	Allied Health	
	Anesthetist	Program	Program		Post-Stepdown		
	Cost	Post-Stepdown Adjustments			Adjustments		
	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00		2.00		JA	3.00	
50. 00   05000   OPERATING ROOM	0	0		0	0	0	50.00
53. 00   05300   ANESTHESI OLOGY	800, 865	_		0	0	Ö	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	Ö	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
60. 00   06000   LABORATORY	0	0		0	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	0	66. 00
66. 01   06601   CARDI AC REHAB	0	0		0	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72. 00 07200 I MPL. 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
76. 01   03950   PAIN CLINIC / SERVICE 76. 02   03530   SNF PHYSICAL THERAPY - SCC THERAPY	0	0		0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS	0	0		U	U	U	76.02
88. 00 08800 RURAL HEALTH CLINIC	1 0	0		0	0	0	88.00
88. 01   08801 RURAL HEALTH CLINIC II		0		0	0	0	88. 01
90. 00   09000  CLINI C	0	0		0	0	0	90.00
91. 00   09100   EMERGENCY	1 0	1 0		0	0	Ö	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	ا	Ö	92.00
93. 00 04040 FAMILY PRACTICE	0	0		0	0	Ö	93.00
200.00 Total (lines 50 through 199)	800, 865	1		0	0		200.00

		W DWEST MEDI	041 051/755			6.5. 040.4	
Health Financial Systems APPORTIONMENT OF INPATIENT/OUT	DATIENT ANGLILARY CER	MI DWEST MEDI		CN 14 1202	In Lie Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	PATTENT ANCILLARY SER	RVICE UTHER PAS	S Provider C		Period: From 10/01/2022	Part IV	
THROUGH COSTS			Component		To 09/30/2023		pared: 09 am
			Title	XVIII	Skilled Nursing		
					Facility		
Cost Center Descri	pti on	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4.00	F 00	/ 00	7.00	instructions)	
ANCILLARY CERVICE COCT O	CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST C	ENTERS	0	0		0 6, 389, 235	0. 000000	50.00
53. 00   05300   ANESTHESI OLOGY		0					
54. 00   05400   RADI OLOGY - DI AGNOST	1.0	0	1		0 1, 410, 918 0 7, 883, 494		
57. 00   05700   CT   SCAN	I C	0	0		0 7,883,494	0.000000	1
58. 00   05800   MAGNETIC RESONANCE	IMACING (MPL)	0	0		0 0	0.000000	
60. 00   06000   LABORATORY	IWAGING (WKI)	0	0		0 4, 762, 694		
64. 00   06400   NTRAVENOUS THERAP	V		0		0 942, 417	0.000000	
65. 00 06500 RESPIRATORY THERAP		0			0 66, 699	0.000000	
66. 00   06600   PHYSI CAL THERAPY	1	0			0 4, 438, 531	0.000000	
66. 01   06601 CARDI AC REHAB		0	0		0 241, 760	0.000000	
67. 00 06700 OCCUPATI ONAL THERA	DV	0	0		0 396, 117	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	. 1	0	١		250, 138		
69. 00   06900   ELECTROCARDI OLOGY		0	٥		0 200, 100	0. 000000	
71. 00 07100 MEDICAL SUPPLIES C	HARGED TO PATIENTS	0	0		2, 188, 525	0. 000000	
72. 00   07200   MPL. DEV. CHARGED		0	0		0 0	0. 000000	
73. 00 07300 DRUGS CHARGED TO P		0	Ö		3, 550, 175	0. 000000	
76. 00 03020 SLEEP LAB		0	Ö		0 0	0. 000000	
76. 01 03950 PAIN CLINIC / SERV	I CE	0	o		0	0. 000000	
76. 02 03530 SNF PHYSICAL THERA		0	o		0	0. 000000	
OUTPATIENT SERVICE COST	CENTERS			•			
88. 00 08800 RURAL HEALTH CLINI	С	0	0		0 2, 192, 669	0.000000	88. 00
88.01 08801 RURAL HEALTH CLINI	CII	0	0		0 672, 548	0.000000	88. 01
90. 00  09000 CLI NI C		0	0		0 203, 499	0. 000000	90.00
91.00 09100 EMERGENCY		0	0		3, 385, 991	0. 000000	
92.00 09200 OBSERVATION BEDS (	NON-DISTINCT PART)	0	0		0 450, 756		
93.00 04040 FAMILY PRACTICE		0	0		0 0	0.000000	
200.00   Total (lines 50 th	rough 199)	0	800, 865		0 39, 426, 166	l I	200. 00

Health Financial Systems	MIDWEST MEDICA	I CENTED		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	CN: 14-1302	Peri od:	Worksheet D	2332-10
THROUGH COSTS		Component (	CCN: 14-6140	From 10/01/2022 To 09/30/2023		
		Title	XVIII	Skilled Nursing	PPS	07 diii
				Facility		
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	9	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col . 7)		x col. 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0. 000000	0		0 0		
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	
57. 00   05700   CT   SCAN	0. 000000	0		0 0	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00   06000   LABORATORY	0. 000000	0		0	0	1
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	0		0 0	0	
66. 01   06601   CARDI AC   REHAB	0. 000000	0		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	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. 000000	0		0	0	73.00
76. 00   03020   SLEEP LAB	0. 000000	0		0	0	
76. 01   03950   PAIN CLINIC / SERVICE	0. 000000	0		0 0	0	
76. 02 03530 SNF PHYSI CAL THERAPY - SCC THERAPY	0. 000000	0		0 0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0. 000000	0		0 0		
88. 01   08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	
91. 00   09100   EMERGENCY	0. 000000	0		0	0	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
93. 00   04040   FAMILY PRACTICE	0. 000000	0		0 0	0	
200.00   Total (lines 50 through 199)		0		0 0	0	200.00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1302	Peri od: From 10/01/2022	Worksheet D-1
			Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	2/23/2024 11:	09 am_
	Cost Center Description	I II LI E XVIII	Hospi tal	Cost	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	es eveluding newborn)		2, 617	1.00
2. 00	Inpatient days (including private room days, excluding swing-	,		1, 029	2.00
3.00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3. 00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	786 278	4. 00 5. 00
5.00	reporting period	om days) through becembe	er 31 of the cost	2/8	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	1, 167	6.00
	reporting period (if calendar year, enter 0 on this line)	<b>3</b>			
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	53	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	11 of the cost	90	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember e	or the cost	70	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	500	9. 00
40.00	newborn days) (see instructions)			075	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	275	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	908	11. 00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including privat	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar y			U	13.00
14.00	Medically necessary private room days applicable to the Progr			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
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
17.00	reporting period	es till odgir becember 31 c	in the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	188. 64	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	194. 30	20.00
	reporting period				
21.00				4, 315, 003	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00		31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)				
24.00	] 3 11 31	r 31 of the cost reporti	ng period (line	9, 998	24. 00
25 00	7 x line 19)   Swing-bed cost applicable to NF type services after December	21 of the cost reporting	noried (line 9	17, 487	25. 00
23.00	x line 20)	or the cost reporting	perrou (Trie o	17, 407	25.00
	Total swing-bed cost (see instructions)			2, 531, 713	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 783, 290	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had sh	argos)	0	28. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	iai yes)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x li		(10113)	0.00	
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 di	fferential (line	1, 783, 290	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 733. 03	38.00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		866, 515	
	Medically necessary private room cost applicable to the Progr	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	l	866, 515	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	MIDWEST MEDI				u of Form CMS-2 Worksheet D-1	
			Titl		To 09/30/2023	2/23/2024 11:	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	Program Cost (col. 3 x col. 4)	
40.00	NUDCEDY (1) II - V o VIV - I - )	1. 00	2.00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					I	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col	3 line 200)			1. 00 646, 846	48.00
48. 01	Program inpatient cellular therapy acquisiti			t III, line 10,	column 1)	0	
49. 00	Total Program inpatient costs (sum of lines	41 through 48.	01)(see instru	uctions)		1, 513, 361	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routino	convices (fr	om Wkst D su	m of Dorte L and	0	50.00
30.00	Pass through costs appricable to Program The	atrent routine	services (iii	JIII WKSt. D, SUI	II OI PALLS I AIIO		30.00
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (1	from Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	EO and E1)				0	52.00
53.00	Total Program inpatient operating cost exclu		elated. non-ph	nvsician anestl	netist and	0	
	medical education costs (line 49 minus line						
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
55. 01	Permanent adjustment amount per discharge					0. 00	
55. 02	Adjustment amount per discharge (contractor use only)						55.0
56. 00 57. 00							56. 0 57. 0
58. 00						0	58.0
59. 00	9.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,					0.00	59.0
60 00	updated and compounded by the market basket) 0.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					0. 00	60.0
61. 00	market basket) Continuous improvement bonus payment (if lir		. ,	•		0.00	
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instr	uctions)			0	63.0
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	ng period (See	476, 583	64.0
<b>.</b>	instructions)(title XVIII only)		04 . 6			4 570 504	/ - 0
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its after Decem	ber 31 of the	cost reporting	g period (See	1, 573, 591	65.0
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	I only); for	2, 050, 174	66.0
47 00	CAH, see instructions	o costo these	h Docombo 24	of the e	nortina n!-!		47.0
67. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ie costs throug	n becember 31	or the cost re	eporting period	0	67.0
68. 00	Title V or XIX swing-bed NF inpatient routir	e costs after	December 31 of	f the cost rep	orting period	0	68.0
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 : lir	ne 68)		0	69.0
57.00	PART III - SKILLED NURSING FACILITY, OTHER N					U	37.0
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37)	)		70.0
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		line 70 ÷ line	2)		I	71.00
73.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)		I	73.0
74. 00	Total Program general inpatient routine serv	rice costs (lin	e 72 + line 73	3)		l	74.0
75. 00	Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B, I	Part II, column	I	75.0
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)				I	76.0
77. 00	Program capital-related costs (line 9 x line	76)				I	77.0
78. 00 79. 00	Inpatient routine service cost (line 74 minu		providor roca:	-de)		I	78. 0 79. 0
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp		•		nus line 79)	I	80.0
81. 00	Inpatient routine service cost per diem limi	tati on		, /3 /		I	81.0
82.00	Inpatient routine service cost limitation (I		*			I	82.0
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		ns)			I	83.0
85.00	Utilization review - physician compensation		ons)			I	85.0
86. 00	Total Program inpatient operating costs (sum	of lines 83 t					86.0
	PART IV - COMPUTATION OF OBSERVATION BED PAS					0.10	
87. 00	Total observation bed days (see instructions	(;)				243	87.0

Health Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			421, 126	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	778, 906	4, 315, 003	0. 18051	1 421, 126	76, 018	90.00
91.00 Nursing Program cost	0	4, 315, 003	0.00000	0 421, 126	0	91.00
92.00 Allied health cost	o	4, 315, 003	0.00000	0 421, 126	0	92.00
93.00 All other Medical Education	o	4, 315, 003	0. 00000	0 421, 126	0	93. 00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1302	Peri od: From 10/01/2022	Worksheet D-1
	Component CCN: 14-6140	To 09/30/2023	Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing	PPS
		Facility	

2.00 Injection to days (including private room days, excluding swing-bed and newborn days) 0 2.00 Private room days (cut uding swing-bed and observation bod days). If you have only private room days (cut uding swing-bed and observation bod days). If you have only private room days (cut uding swing-bed and observation bod days). If you have only private room days (cut uding swing-bed and observation bod days). If you have the cut used to reporting period (if calendar year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days (including private room days) after Becember 31 of the cost reporting period (if calendar year, enter 0 on this line).  8.00 Interior period (if calendar year, enter 0 on this line).  9.00 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).  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions).  10.00 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).  12.00 Swing-bed SNF type inpatient days applicable to title VIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  12.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days).  13.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days).  14.00 Newborn days (see instructions).  15.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days).  16.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period.  17.00 Newborn days applicable to NF services applicable to services after December 31 of the cost reporting period.  18.00 Newborn days applicable to NF type servic			II the Aviii	Facility	FF3	
PART   - ALL PROVIDER COMPONENTS		Cost Center Description			1.00	
Impatient days (including private room days and swing-bed days, excluding neeborn)   0   1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
1. Inpatient days (including private room days, excluding saring-bed and newborn days) 0. 2.00 Private room days (secturing period) 0. 3.00 private room days) 0. 3.00 private room days (secturing period) 0. 3.00 private room days) 0. 3.00 private room day		I NPATI ENT DAYS				
2.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. ine. do not complete this line line. Total swing-bed SNF type inpatient days. (including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line).  7.00 Total swing-bed SNF type inpatient days. (including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line).  8.00 Total swing-bed SNF type inpatient days. (Including private room days) after December 31 of the cost reporting period. (I calendar year, enter 0 on this line).  9.00 Total impatient days including private room days applicable to the Program (excluding swing-bed and newtorn days). See instruction days applicable to title xVIII only (including private room days). If the cost reporting period. (I calendar year, enter 0 on this line).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days). If the cost reporting period. (I calendar year, enter 0 on this line).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days). If the cost reporting period. (I calendar year, enter 0 on this line).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days).  10.00 Saing-bed SNF type inpatient days applicable to title xVIII only (including private room days).  10.00 Saing-bed SNF type inp	1.00					1.00
do not complete this line.  4. 06 Semi-private room days (excluding swing-bed and observation bed days)  5. 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)  7. 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)  7. 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)  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)  9. 01 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and lots)  10. 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)  10. 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)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10. 00 Swing-bed NF type inpatient days applicable to titles VI or XIX only (including private room days)  10. 00 Swing-bed NF type inpatient days applicable to titles VI or XIX only (including private room days)  10. 00 Swing-bed NF type inpatient days applicable to titles VI or XIX only (including private room days)  10. 00 Swing-bed SNF type inpatient days applicable to services after December 31 of the cost reporting period (including trivate room days)  10. 00 Swing-bed SNF type inpatient days applicable to services after December 31 of the cost reporting period (including trivate room days)  10. 00 Swing-bed cost applicable to SNF type services after December 31 of the co				ivate room days		
101al swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (inc	3.00		ys). If you have only pr	Tvate room days,	O	3.00
reporting period.  On Total swing-bed SNR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  Total swing-bed NR type inpatient days (including private room days) through December 31 of the cost of the swing-bed NR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  Total inpatient days (including private room days) after December 31 of the cost reporting period diffication days) (see instructions).  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Through December 31 of the cost reporting period (see instructions).  Medicare rate for swing-bed SNF services applicable to titles V or XIX only (including private room days).  Through December 31 of the cost reporting period (see instructions).  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions).  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (see instructions).  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of the period sylicable to SNF type services through December 31 of the cost reporting period (line of the period sylicable to SNF type serv	4.00	Semi-private room days (excluding swing-bed and observation b				4.00
10tal swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10tal swing-bed NF type Inpatient days (Including private room days) after December 31 of the cost reporting period (in patient) period (in patient	5. 00		om days) through Decembe	er 31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line)  No Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  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)  Notal impatient days including private room days applicable to the Program (excluding swing-bed and 0 9,000 on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Notal impatient days including private room days applicable to the Program (excluding swing-bed and 0 9,000 on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Notal period Sking-bed Sking-bed Sking-bed sapplicable to title Skill (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Notal period NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this line)  Notal Proporting period (if calendar year, enter 0 on this li	6 00		om days) after December	31 of the cost	0	6.00
reporting period  Total inpatient days (including private room days) after becember 31 of the cost reporting period (If calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  White phed SMF type inpatient days applicable to title XVIII only (including private room days)  Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after become 31 of the cost reporting period (see instructions)  Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after become 31 of the cost reporting period (see instructions)  Swing-bed SMF type inpatient days applicable to titles Vor XIX only (including private room days) after become 31 of the cost reporting period (all calendar year, enter 0 on this line)  White placember 31 of the cost reporting period (if calendar year, enter 0 on this line)  White placember 31 of the cost reporting period (if calendar year, enter 0 on this line)  White call I y necessary private room days applicable to the Program (excluding swing-bed days)  Union (if the cost reporting period (if calendar year, enter 0 on this line)  White Call I y necessary private room days applicable to the Program (excluding swing-bed days)  Union (if the cost reporting period (if	0.00		om days) arter becember	or or the cost	O	0.00
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reporting period (if cal endar year, énter 0 on this line)  10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  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 (see instructions)  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 cal endar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  17.00 Medicar prate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Swing-Beb ADJUSTMENT  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line or reporting period (including private room days)  18.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line or reporting period (including swing-bed charges)  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or reporting period	9 00	' 3 '	m days) after December 2	1 of the cost	0	0 00
Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)   0.00   0.00	8.00		ili days) ai tei beceilibei 3	i or the cost	U	8.00
3. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0   10. 00	9.00		o the Program (excluding	swing-bed and	0	9. 00
through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to fittle XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Total general inpatient routine service cost (see instructions)  29.756 June 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 1 line 18)  29.750 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 1 line 18)  29.750 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x 1 line 18)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 1 line 20)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 1	10.00					40.00
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Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   20.00   Total general inpatient routine service cost (see instructions)   29,756   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   27.00   Contain swing-bed cost (see instructions)   26.00   27.00   28.00   27.00   28.00   27.00   28.00   28.00   29.	18. 00	,	es after December 31 of	the cost		18.00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00  Total general inpatient routine service cost (see instructions)  20.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  26.00  Total swing-bed cost (see instructions)  27.00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service cost/charges (excluding swing-bed and observation bed charges)  29.00  Private room charges (excluding swing-bed charges)  30.00  Semi-private room charges (excluding swing-bed charges)  30.00  Average private room per diem charge (line 29 + line 3)  30.00  Average per diem private room charge (line 30 + line 4)  30.00  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00  Average per diem private room charge differential (line 32 minus line 33)  30.00  Private room cost differential adjustment (line 32 minus line 33)  30.00  Private room cost differential adjustment (line 34 x line 31)  30.00  Average per diem private room cost differential (line 32 minus line 33)  30.00  Private room cost differential adjustment (line 32 minus line 33)  30.00  Private room cost differential adjustment (line 32 minus line 34)  30.00	19. 00		s through December 31 of	the cost	0. 00	19.00
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  24.00 In the land of the land	22. 00			ing period (line		22.00
x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)  0 Semi-private room charges (excluding swing-bed charges) 0 Semi-private room charges (excluding swing-bed charges) 0 Semi-private room charges (excluding swing-bed charges) 0 Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28) 0 Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28) 0 Average perivate room per diem charge (line 30 ± line 4) 0 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0 Average per diem private room cost differential (line 34 x line 31) 0 Average per diem private room cost differential (line 34 x line 35) 0 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 29, 756) 0 Average per diem private room cost differential (line 3 x line 35) 0 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 29, 756) 0 Average per diem private room cost differential (line 3 x line 35) 0 Average per diem private room cost differential (line 3 x line 35) 0 Average per diem line service cost net of swing-bed cost and private room cost differential (line 29, 756) 0 Average per diem line service cost net of swing-bed cost and private room cost differential (line 29, 756) 0 Average per diem line service cost net of swing-bed cost and private room cost differential (line 29, 756) 0 Average per diem line service cost (line 9 x line 38) 0 Average per diem line service cost (line 9 x line 38)		/	•			
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41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   41.00	40.00					40.00
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)			41.00

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COMI CIATIC	or ThirATTENT OF ENATING 3031				From 10/01/2022 To 09/30/2023		
			Ti +1 4	e XVIII	Skilled Nursing	2/23/2024 11: PPS	09 am
					Facility		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42 00 NIIB	SERY (title V & XIX only)	1. 00	2.00	3. 00	4. 00	5. 00	42.0
	ensive Care Type Inpatient Hospital Units						72.0
43. 00   I NT	ENSIVE CARE UNIT						43.0
	ONARY CARE UNIT						44.0
	N INTENSIVE CARE UNIT GICAL INTENSIVE CARE UNIT						45. C
	ER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
48.00 Pro	gram inpatient ancillary service cost (Wk	st. D-3. col.	3. Line 200)			1. 00	48.0
48. 01 Pro	gram inpatient cellular therapy acquisition	on cost (Works	sheet D-6, Part	III, line 10	, column 1)		48.0
	al Program inpatient costs (sum of lines	41 through 48.	01)(see instru	ctions)			49.0
	S THROUGH COST ADJUSTMENTS s through costs applicable to Program inp	ationt routing	sorvices (fre	m Wkst D su	m of Darts I and	1	50.0
111		atrent routine	services (iid	ill WKSt. D, Sui	ii Oi Fai ts i aiic		30.0
51.00 Pas	s through costs applicable to Program inp	atient ancilla	ary services (f	rom Wkst. D,	sum of Parts II		51.0
1	IV)	50 and 51)					E2 (
	al Program excludable cost (sum of lines ! al Program inpatient operating cost exclu		elated, non-ph	vsician anest	hetist and		52. C
med	ical education costs (line 49 minus line						]
	GET AMOUNT AND LIMIT COMPUTATION						
	gram discharges get amount per discharge						54. C
	manent adjustment amount per discharge						55.0
	ustment amount per discharge (contractor						55.
	get amount (line 54 x sum of lines 55, 55			line E4 minue	Line E2)		56.
4						57. 58.	
						59.	
	updated and compounded by the market basket)						
	.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					60.0	
61. 00 Con	.00   Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus					61.0	
	01, or line 59, or line 60, enter the less are less than expected costs (lines 54 x						
ent	er zero. (see instructions)	, .	J	•			
	ief payment (see instructions) owable Inpatient cost plus incentive paym	ont (soo instr	cuctions)				62.0
	GRAM INPATIENT ROUTINE SWING BED COST	ent (see mstr	uctions)				_ 03. (
	icare swing-bed SNF inpatient routine cos	ts through Dec	cember 31 of th	e cost report	ing period (See		64. (
	tructions)(title XVIII only) icare swing-bed SNF inpatient routine cos	ts after Decem	her 31 of the	cost reporting	a period (See		65. (
	tructions)(title XVIII only)	ts arter becen	ibel 31 01 tile	cost reporting	g perrou (see		05.
66. 00 Tot	al Medicare swing-bed SNF inpatient routi	ne costs (line	e 64 plus line	65)(title XVI	II only); for		66.0
	, see instructions le V or XIX swing-bed NF inpatient routin	e costs throug	nh December 31	of the cost r	enorting period		67.0
	ne 12 x line 19)	c costs till oug	jii becember 31	or the cost I	oporting period		37.0
68.00 Tit	le V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost rep	orting period		68.0
	ne 13 x line 20) al title V or XIX swing-bed NF inpatient :	routine costs	(line 67 ± lin	ne 68)			69. (
PAR <sup>-</sup>	T III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILIT	Y, AND ICF/IID	ONLÝ			1 07. (
70. 00 Ski	lled nursing facility/other nursing facil	ity/ICF/IID ro	outine service	cost (line 37)	)	29, 756	
	usted general inpatient routine service or		line 70 ÷ line	2)		0.00	1
1	gram routine service cost (line 9 x line i ically necessary private room cost applic	,	am (line 14 x l	ine 35)		0	1
	al Program general inpatient routine serv					Ö	74. (
	ital-related cost allocated to inpatient	routine servic	ce costs (from	Worksheet B,	Part II, column	0	75. (
	line 45) diem capital-related costs (line 75 ÷ li	ne 2)				0. 00	76.
77.00 Pro	gram capital-related costs (line 9 x line	76)				0.00	1
	atient routine service cost (line 74 minus			1.3		0	1 .
	regate charges to beneficiaries for excessal Program routine service costs for comp				nus lina 70)	0	
1	atient routine service costs for compa atient routine service cost per diem limi		COST TIME LATED	ıı (ııne /o MI	ilus IIIIe /9)	0. 00	
	atient routine service cost limitation (		31)			0.00	
33. 00 Rea	sonable inpatient routine service costs (	see instructio				0	1
	gram inpatient ancillary services (see in:		one)			0	
	lization review - physician compensation al Program inpatient operating costs (sum					0	
	TIV - COMPUTATION OF OBSERVATION BED PASS						] 33.
	al observation bed days (see instructions	`					87.

Health Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component	CCN: 14-6140	From 10/01/2022 To 09/30/2023		pared: 09 am_
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
				,	1. 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) (se	e instructions)	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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. 00000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00
·			•	,	·	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1302	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Pre 2/23/2024 11:	pared:
	Titl∈	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00   03000   ADULTS & PEDI ATRI CS			1, 168, 542		30.00
42. 00 04200 SUBPROVI DER			0		42.00
ANCILLARY SERVICE COST CENTERS		0.0054	500 (00	100.000	
50. 00   05000   OPERATING ROOM		0. 3956		199, 298	
53. 00   05300   ANESTHESI OLOGY		0. 6290		10, 094	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2903	· ·	26, 323	
57. 00   05700   CT   SCAN		0.0000		0	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.00
60. 00   06000   LABORATORY		0. 3542		41, 618	1
64. 00 06400 I NTRAVENOUS THERAPY		0. 0898		10	
65. 00   06500   RESPI RATORY   THERAPY		1. 4114	· ·	14, 328	
66. 00   06600   PHYSI CAL THERAPY		0. 6948		76, 393	
66. 01   06601   CARDI AC   REHAB		1. 0843		0	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6830		19, 322	
68. 00   06800   SPEECH PATHOLOGY		0. 5972		8, 981	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6518		152, 226	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3131		95, 043	
76. 00   03020   SLEEP LAB		0.0000		0	
76. 01   03950   PAIN CLINIC / SERVICE		0.0000		0	
76. 02 03530 SNF PHYSICAL THERAPY - SCC THERAPY OUTPATIENT SERVICE COST CENTERS		0.0000	00  0	0	76. 0
88. 00   08800   RURAL HEALTH CLINIC		0.0000	00	0	88. 00
88.01   08801 RURAL HEALTH CLINIC		0.0000		0	
90. 00   09000   CLINIC		4. 3777		0	
90. 00   09000  CLINIC 91. 00   09100  EMERGENCY		4. 3777 0. 9473		3, 210	
91.00   09100  EMERGENCY 92.00   09200  OBSERVATION BEDS (NON-DISTINCT PART)		0. 9473		3,210	
93. 00   04200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 9342		0	
93.00   04040 FAMILY PRACTICE 200.00   Total (sum of lines 50 through 94 and 96 through	. 00)	0.0000		_	
201.00 Less PBP Clinic Laboratory Services-Program only		1	1, 431, 818	040, 840	200.00
202.00 Net charges (line 200 minus line 201)	y charges (Title 61)		1, 431, 818		201.00

	Financial Systems MI DWEST MEDICAL	CENTER			u of Form CMS-	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1302	Peri od:	Worksheet D-3	
		Component	CCN: 14-Z302	From 10/01/2022 To 09/30/2023		
		Title	XVIII	Swing Beds - SNI		
	Cost Center Description		Ratio of Cos	st Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
42.00	04200 SUBPROVI DER					42.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 3956			
53.00	05300 ANESTHESI OLOGY		0. 6290			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2903			
57.00	05700 CT SCAN		0.0000		0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			58.00
60.00	06000 LABORATORY		0. 3542		30, 392	
64. 00	06400 I NTRAVENOUS THERAPY		0. 0898			64.00
65. 00	06500 RESPI RATORY THERAPY		1. 4114	· ·		65.00
66. 00	06600 PHYSI CAL THERAPY		0. 6948			66.00
66. 01	06601 CARDI AC REHAB		1. 0843		_	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY		0. 6830			
68. 00	06800 SPEECH PATHOLOGY		0. 5972			68. 00
69. 00	06900 ELECTROCARDI OLOGY		0.0000			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6518			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3131			73.00
76. 00	03020 SLEEP LAB		0.0000		_	76.00
	03950 PAIN CLINIC / SERVICE		0.0000		_	76. 01
76. 02	03530 SNF PHYSICAL THERAPY - SCC THERAPY		0.0000	00 0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.0000		0	
88. 01	08801 RURAL HEALTH CLINIC II		0.0000		0	88. 01
90.00	09000 CLI NI C		4. 3777			90.00
91. 00	09100 EMERGENCY		0. 9473			1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9342		_	92.00
	04040 FAMILY PRACTICE		0.0000		0	93.00
200.00				1, 232, 178	660, 346	
201.00		s (line 61)		C		201. 00
202.00	Net charges (line 200 minus line 201)		1	1, 232, 178	1	202. 00

	ANCILLARY SERVICE COST APPORTIONMENT		CN: 14-1302	Do:	ri od:	u of Form CMS-2 Worksheet D-3	
INPAILENI /	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 14-1302		om 10/01/2022	WOLKSHEET D-3	
		'	CCN: 14-6140	То	09/30/2023	Date/Time Pre 2/23/2024 11:	
		Ti tl e	e XVIII	Ski	illed Nursing	PPS	
	Coat Contan Decemintion		Ratio of Cos	.+	Facility	Inpati ent	
	Cost Center Description		To Charges		Inpatient Program	Program Costs	
			10 Charges		Charges	(col. 1 x	
					onal goo	col . 2)	
			1.00		2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDI ATRI CS						30.0
	O SUBPROVI DER						42.0
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0. 3956	02	0	0	50. c
	O ANESTHESI OLOGY		0. 3930		0	0	
1	O RADI OLOGY-DI AGNOSTI C		0. 2903		0	0	1
	O CT SCAN		0.0000		Ö	0	
	O MAGNETIC RESONANCE IMAGING (MRI)		0.0000		Ö	0	
	O LABORATORY		0. 3542	18	0	0	60.0
4. 00   0640	O I NTRAVENOUS THERAPY		0. 0898	75	0	0	64.0
	O RESPI RATORY THERAPY		1. 4114		0	0	
	O PHYSI CAL THERAPY		0. 6948		0	0	
	1 CARDI AC REHAB		1. 0843		0	0	66. (
	O OCCUPATIONAL THERAPY		0. 6830		0	0	
- 1	O SPEECH PATHOLOGY		0. 5972		0	0	
	O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0000 0. 6518		0	0	1
	O I MPL. DEV. CHARGED TO PATIENTS		0.0000		0	0	
	O DRUGS CHARGED TO PATIENTS		0. 3131		0	0	1
	O SLEEP LAB		0.0000		Ö	0	
6. 01   0395	O PAIN CLINIC / SERVICE		0.0000	00	0	0	76.0
6. 02 0353	O SNF PHYSICAL THERAPY - SCC THERAPY		0.0000	00	0	0	76.0
	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC		0.0000			0	
	1 RURAL HEALTH CLINIC II		0.0000		_	0	
	O CLINIC		4. 3777		0	0	
	O EMERGENCY		0. 9473 0. 9342		0	0	
	O OBSERVATION BEDS (NON-DISTINCT PART) O FAMILY PRACTICE		0. 9342		0	0	1
3. 00   0404 30. 00	Total (sum of lines 50 through 94 and 96 through 98)		0.0000	UU	0		200.
01.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			0	U	201.
202.00	Net charges (line 200 minus line 201)	(11110 01)			ő		202.0

		Title XVIII	Hospi tal	2/23/2024 11: Cost	09 alli
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1	Medical and other services (see instructions)			5, 434, 415	1. 00
1	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
1	OPPS or REH payments Outlier payment (see instructions)			0	3. 00 4. 00
1	Outlier reconciliation amount (see instructions)			0	4. 00
1	Enter the hospital specific payment to cost ratio (see instructions)	)		0.000	5. 00
	Line 2 times line 5			0	6.00
1	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
	Transitional corridor payment (see instructions)	12 line 200		0	8.00
1	Ancillary service other pass through costs from Wkst. D, Pt. IV, col Organ acquisitions	. 13, TTHE 200		0	9. 00 10. 00
	Total cost (sum of lines 1 and 10) (see instructions)			5, 434, 415	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges  Organ association sharpes (from West D. 4. Dt. III. col. 4. Line (0)			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	1		0	13. 00 14. 00
+	Customary charges			U	14.00
	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 payme	ent for services or	a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				47.00
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000 0	17. 00 18. 00
	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only if I	ine 18 exceeds lin	e 11) (see	0	19.00
	instructions)	THE TO CACCEGO TTT	10 11) (300	G	17.00
20. 00	Excess of reasonable cost over customary charges (complete only if ${\sf I}$	ine 11 exceeds lir	ie 18) (see	0	20.00
1	instructions)			5 400 750	04.00
1	Lesser of cost or charges (see instructions)			5, 488, 759 0	21. 00 22. 00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruction	ns)		0	23.00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	13)		0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
1	Deductibles and coinsurance amounts (for CAH, see instructions)			37, 783	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24 (f			1, 793, 629	26.00
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th instructions)	ne sum of lines 22	and 23] (see	3, 657, 347	27. 00
	Direct graduate medical education payments (from Wkst. E-4, line 50)	)		0	28. 00
	REH facility payment amount				28. 50
1	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
1	Subtotal (sum of lines 27, 28, 28.50 and 29)			3, 657, 347	30.00
	Primary payer payments Subtotal (line 30 minus line 31)			2, 969 3, 654, 378	31. 00 32. 00
H	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			3, 034, 370	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			0	34.00
1	Adjusted reimbursable bad debts (see instructions)			0	35.00
	Allowable bad debts for dual eligible beneficiaries (see instruction Subtotal (see instructions)	is)		0 3, 654, 378	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R			0,034,370	38.00
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
	N95 respirator payment adjustment amount (see instructions)			0	39. 75
1	Demonstration payment adjustment amount before sequestration	daga (aga linatruat	:Lana)	0	39. 97
	Partial or full credits received from manufacturers for replaced dev RECOVERY OF ACCELERATED DEPRECIATION	rices (see instruct	1 0115)	0	39. 98 39. 99
1	Subtotal (see instructions)			3, 654, 378	40.00
	Sequestration adjustment (see instructions)			73, 088	
	Demonstration payment adjustment amount after sequestration			0	40. 02
1	Sequestration adjustment-PARHM pass-throughs			0 (0)	40. 03
1	Interim payments			3, 696, 286	41. 00 41. 01
1	Interim payments-PARHM Tentative settlement (for contractors use only)			0	42.00
	Tentative settlement-PARHM (for contractor use only)			G	42. 01
1	Balance due provider/program (see instructions)			-114, 996	
	Balance due provider/program-PARHM (see instructions)				43. 01
	Protested amounts (nonallowable cost report items) in accordance wit	th CMS Pub. 15-2, c	chapter 1,	0	44. 00
H	§115. 2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
1	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)			0	93.00
94. 00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems	MIDWEST MEDICAL	CENTER	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Peri od:	Worksheet E	
			From 10/01/2022		
			To 09/30/2023	Date/Time Pr	
				2/23/2024 11	1:09 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1302	
		From 10/01/2022   Part B
	Component CCN: 14-6140	To 09/30/2023 Date/Time Prepared:
		2/23/2024 11:09 am
	Title XVIII	Skilled Nursing PPS

	Facility	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1. 00	Medical and other services (see instructions)	0	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments	0	2. 00 3. 00
4. 00	Outlier payment (see instructions)		4.00
4. 01	Outlier reconciliation amount (see instructions)		4. 01
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 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0. 00 0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	i e
10.00	Organ acqui si ti ons	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		ł
12. 00	Ancillary service charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	l
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
15 00	Customary charges  Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15 00
15. 00 16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	o o	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
	Total customary charges (see instructions)	0	1
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	0	20.00
	instructions)		
21.00	Lesser of cost or charges (see instructions)	0	21.00
	Interns and residents (see instructions)	0	22. 00 23. 00
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-	
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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
28. 50	REH facility payment amount		28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	0	30.00 31.00
	Subtotal (line 30 minus line 31)	0	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	0	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
	Subtotal (see instructions)	0	
	MSP-LCC reconciliation amount from PS&R		38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions)  N95 respirator payment adjustment amount (see instructions)	0	39. 50 39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
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
	Subtotal (see instructions) Sequestration adjustment (see instructions)	0	40. 00 40. 01
40. 01	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration	0	40.01
	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	0	1
	Interim payments-PARHM		41.01
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. 00 42. 01
	Balance due provider/program (see instructions)	0	1
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
90. 00	Original outlier amount (see instructions)		90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)		91.00
	The rate used to calculate the Time Value of Money		92.00
93. UU	Time Value of Money (see instructions)	<u> </u>	93.00

Health Financial Systems	MIDWEST MEDICAL	CENTER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Peri od:	Worksheet E	
			From 10/01/2022		
		Component CCN: 14-6140	To 09/30/2023	Date/lime Pre	pared:
				2/23/2024 11:	09 am_
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
94.00 Total (sum of lines 91 and 93)					94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Peri od: Worksheet E-1 From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/23/2024 11:09 am Provider CCN: 14-1302

Interfim 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 "MONE" or enter a zero						2/23/2024 11:0	09 am
1.00			Title	XVIII	Hospi tal	Cost	
1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00			I npati en	Inpatient Part A		rt B	
1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 "MONE" or neter a zero							
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider		1, 302, 71	9	3, 758, 237	1. 00
write "NONE" or enter a zero  NOL List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  OFFICIAL STATES OFFICI	2. 00	submitted or to be submitted to the contractor for			o O	0	2. 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.03 3.04 3.05 3.05 3.06 3.07 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider							
3.01 ADJUSTMENTS TO PROVIDER							
3.02   3.03   3.03   3.04   3.05   3.06   3.07	2 01		OF (00 (2022	45.04	7		2 01
3.04 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.51 3.51 3.52 3.53 3.54 3.59 3.59 3.50 3.59 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50		ADJUSTMENTS TO PROVIDER					
3.05   Provider to Program     0   0   0   3.0			09/19/2023			- 1	
3.05   ADJUSTMENTS TO PROGRAM					-	1	
Provider to Program							
ADJUSTMENTS TO PROGRAM	3. 05	Dravidar to Dragram			J	0	3.05
3.51   0   09/19/2023   15,098   3.57   3.52   0   0   0   3.55   3.53   0   0   0   3.55   3.53   3.53   3.54   0   0   0   3.55   3.54   0   0   0   3.55   3.54   3.59   3.50-3.98	3 50				05/08/2023	46 853	3 50
3.52   0		ADJUSTIMENTS TO TROUBLAND					
3.53   3.54   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,356,185   3,696,286   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,356,185   3,696,286   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,356,185   3,696,286   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,356,185   3,696,286   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,356,185   3,696,286   4.00   Total Medicare program to Program to Program to Program to Provider to Program to Provider   Tentative To PROGRAM   0   0   0   0   0   0   0   0   0							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.5, 466   3					-	· · · · · · · · · · · · · · · · · · ·	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 O1-3 49 minus sum of lines				1	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)		·			
TO BE COMPLÉTED BY CONTRACTOR   Separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   Separately Provider   Separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   Separately each tentative settlement agency   Separately   Separately each tentative settlement agency   Separately   Se	4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 350, 18		3, 696, 286	4.00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	E 00						E 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER							
5. 02	5 01				1	0	5 01
Solution   Settlement amount (balance due) based on the cost report. (1)   Settlement TO PROGRAM   S		TENTITIVE TO TROVIDER					5. 02
TENTATI VE TO PROGRAM							5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 0 5.50 0 0 5.50 0 0 5.50 0 0 0 6.00 0 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Provider to Program					
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  O 1.00 2.00	5.50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)   Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00	5. 51				o	0	5. 51
5.50-5.98   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   0   0   0   6.00	5. 52				0	0	5. 52
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00	5. 99				D	0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  35,503 1,320,682  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01				0	n	6 01
7.00 Total Medicare program liability (see instructions)  1,320,682  3,581,290 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00					-	- 1	6. 02
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00							7. 00
0 1.00 2.00		,		1, 222, 00.	Contractor	NPR Date	50
			0				
	8. 00	Name of Contractor			00	2.00	8. 00

		'			2/23/2024 11:	09 am
				wing Beds - SNF		
		Inpatien	t Part A	Par	t 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, 407, 522	2	0	1.00
2.00	Interim payments payable on individual bills, either		(		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	05/08/2023	73, 467		0	3. 01
3. 02		09/19/2023	27, 545		0	3. 02
3. 03			C		0	3. 03
3. 04			(		0	3. 04
3.05			(	)	0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		101, 012	2	0	3. 99
4 00	3. 50-3. 98)		0 500 50			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 508, 534	ŀ	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C	)	0	5. 01
5. 02	TERMINE TO TROTTEEN				Ö	5. 02
5. 03					0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C	)	0	5.50
5. 51			Ċ		0	5. 51
5. 52			Ċ		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		Ċ		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		130, 524	I.	0	6. 01
6.02	SETTLEMENT TO PROGRAM		(		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 639, 058	3	0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems MID

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED MI DWEST MEDICAL CENTER Provi der CCN: 14-1302 Component CCN: 14-6140

Title XVIII

		Title	XVIII S	Skilled Nursing Facility	PPS	
		I npati en	it Part A	Par	t 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	
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	3. 02
3. 03 3. 04			0		0	3. 03 3. 04
3. 04						3.04
3.05	Provider to Program			1	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		Ō	3. 51
3. 52			0	)	0	3. 52
3. 53			0		0	3. 53
3.54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		0		0	4 00
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		0	,	U	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provi der TENTATI VE TO PROVI DER				0	   <sub>- 01</sub>
5. 01 5. 02	TENTATIVE TO PROVIDER		0 0			5. 01 5. 02
5. 02						
0.00	Provider to Program			1		0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0	1	0	5. 51
5. 52			0		0	0.02
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
/ 00	5. 50-5. 98)					/ 00
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		ĺ			6. 02
7. 00	Total Medicare program liability (see instructions)		0		Ō	ı
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor			1	l l	8. 00

Heal th	Financial Systems MIDWEST MEDICA	L CENTER	In Lie	u of Form CMS-	2552-10	
CALCUL	From 10/01/2022 Pa To 09/30/2023 Da				epared:	
	Title XVIII Hospital					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00	
1.00	1.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00   Medicare days (see instructions)				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days (see instructions)				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 I	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of a	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
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 l	ine 31) (see instructio	ns)		32.00	

Health Financial Systems	MIDWEST MEDICAL	_ CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1302	Peri od: From 10/01/2022	Worksheet E-2
		Component CCN: 14-Z302	To 09/30/2023	Date/Time Prepared: 2/23/2024 11:09 am

		Component CCN: 14-Z302	To 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Title XVIII	Swing Beds - SNF		07 diii
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1	_	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2, 070, 676	0	
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	666, 949	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	na-hed nass-through see	000, 747	l	3.00
	instructions)	ng-bed pass-till ough, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4. 00
	instructions)				
5.00	Program days		1, 183		5. 00
6.00	Interns and residents not in approved teaching program (see i			0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	0 727 (25		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		2, 737, 625	0	
10.00	Subtotal (line 8 minus line 9)		2, 737, 625		
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	2, 737, 023	0	
11.00	professional services)	cable to physician		l	11.00
12.00	Subtotal (line 10 minus line 11)		2, 737, 625	0	12.00
13.00	Coinsurance billed to program patients (from provider records	) (exclude coinsurance	44, 709	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (see instructions)		2, 692, 916		15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction				16.50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
16. 99	adjustment (see instructions)  Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	Ö	
17. 01	Adjusted reimbursable bad debts (see instructions)		O	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
19.00	Total (see instructions)		2, 692, 916	0	19. 00
19. 01	Sequestration adjustment (see instructions)		53, 858	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	, ,			_	19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0 500 504	0	
20. 00 20. 01	Interim payments		2, 508, 534	0	20.00
21. 00	Interim payments-PARHM Tentative settlement (for contractor use only)		0	0	20.01
21. 00	Tentative settlement-PARHM (for contractor use only)			l	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2. 19.25. 20. and 21)	130, 524	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	_,,,,	,	1	22. 01
23.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonst				
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				_
201 00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
201.00	66 (title XVIII hospital))	wkst. D-1, Ft. II, IIIle			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst D-3 col 3 line	7	1	202.00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	nt 5-year demons	trati on	
005 00	peri od)				005 00
	Medicare swing-bed SNF target amount	i 1 i 204)		l e	205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur				206. 00
207 00	Program reimbursement under the \$410A Demonstration (see inst	ructions)			207. 00
	07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1		ł	208.00	
200.00	and 3)	2, 501. 1, 3um 01 111165 1			
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use	,		l e	210.00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)		1	l	l

Health Financial Systems	MIDWEST MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1302	From 10/01/2022	Worksheet E-3 Part V Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hosni tal	Cost

				2/23/2024 11:	09 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 513, 361	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3.00	Organ acquisition	•		0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 513, 361	4.00
5. 00	Primary payer payments			0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 528, 495	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 020, 170	0.00
	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
10.00	J			U	10.00
11. 00	Customary charges Aggregate amount actually collected from patients liable for p	normant for convices on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for				12.00
12.00	· ·		on a charge basis	. 0	12.00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	13. 00
13. 00 14. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	14.00
15. 00	Total customary charges (see instructions)	v if line 14 evenede li	no () (coo	0	
15.00	Excess of customary charges over reasonable cost (complete onl	y II IIIle 14 exceeds II	ne o) (see	Ü	15. 00
14 00	instructions)	vifling ( avagada lin	0 14) (000	0	17 00
16. 00	Excess of reasonable cost over customary charges (complete onl	y II IIIle 6 exceeds III	ie 14) (See	0	16. 00
17 00	instructions)			0	17. 00
17. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	17.00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1 1: 40)		0	10.00
18.00	Direct graduate medical education payments (from Worksheet E-4	i, Tine 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 528, 495	
20.00	Deductibles (exclude professional component)			180, 860	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 347, 635	
23. 00	Coinsurance			0	23.00
24. 00	Subtotal (line 22 minus line 23)			1, 347, 635	
25. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		0	25.00
26. 00	Adjusted reimbursable bad debts (see instructions)			0	26.00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	27.00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 347, 635	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 347, 635	30.00
30. 01	Sequestration adjustment (see instructions)			26, 953	30. 01
30.02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			1, 356, 185	31.00
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02	2, 31, and 32)		-35, 503	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi		and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accordan			0	34.00
	§115. 2	,			
	• -				•

	Financial Systems MIDWEST MEDI	Provider CCN: 14-1302	Peri od:	wof Form CMS-: Worksheet E-3	
		Component CCN: 14-6140	From 10/01/2022 To 09/30/2023	Part VI	epare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL (	OTHER HEALTH SERVICES FOR	TITLE XVIII PART		
	SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
00	Resource Utilization Group Payment (RUGS)			0	
00	Routine service other pass through costs			0	2.
00	Ancillary service other pass through costs			0	1 -
	Subtotal (sum of lines 1 through 3)			0	4.
	COMPUTATION OF NET COST OF COVERED SERVICES				4
00	Medical and other services (Do not use this line as vaccing	e costs are included in li	ne 1 of W/S E,		5.
	Part B. This line is now shaded.)			_	١
	Deducti bl e			0	_
	Coinsurance			0	
	Allowable bad debts (see instructions)			0	-
00	Reimbursable bad debts for dual eligible beneficiaries (se	e instructions)		0	1
	Adjusted reimbursable bad debts (see instructions)			0	
	Utilization review	40 141 ( )	,	0	
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	s 10 and 11)(see instructi	ons)	0	
	Inpatient primary payer payments			0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	
	Recovery of accelerated depreciation.			0	
	Demonstration payment adjustment amount before sequestration	on		0	
	Subtotal (see instructions			0	
	Sequestration adjustment (see instructions)	_		0	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration for non-claims based amounts (see instruction	ns)		0	1
	Interim payments			0	
	Tentative settlement (for contractor use only)	F 00 4F 7F 4/ 47\		0	
	Balance due provider/program (line 15 minus lines 15.01, 19 Protested amounts (nonallowable cost report items) in acco		0 1 1 1 1 1	0	1
9. 00					

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

Provider CCN: 14-1302

UIII y)					2/23/2024 11:	09 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
1.00	Cash on hand in banks	2, 660, 323	0	0	0	
2.00	Temporary investments	0	0	0	0	1
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7, 857, 147		0	0	
5. 00	Other receivable	109, 184		0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-2, 753, 107 495, 563		0	0	6. 00 7. 00
8. 00	Prepai d expenses	345, 903		0	0	
9. 00	Other current assets	0 343, 703		0	0	
10.00	Due from other funds	Ö	o o	0	0	
11.00	Total current assets (sum of lines 1-10)	8, 715, 013	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	448, 597		0	0	12.00
13. 00	Land improvements	4, 011, 958		0	0	13.00
14.00	Accumulated depreciation	-3, 096, 623		0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	38, 956, 780		0	0	15. 00 16. 00
17. 00	Leasehold improvements	-25, 183, 324		0	0	17.00
18. 00	Accumulated depreciation			0	0	18.00
19. 00	Fi xed equipment	Ö	o o	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	9, 746, 688		0	0	23. 00
24.00	Accumulated depreciation	-6, 685, 117	0	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0 770 050		0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	2, 772, 852 -2, 691, 290		0	0	27. 00 28. 00
29.00	Mi nor equi pment-nondepreci abl e	5, 232, 226		0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23, 512, 747		0	0	30.00
00.00	OTHER ASSETS	20,012,717	<u> </u>			00.00
31.00	Investments	16, 035, 197	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, 674, 543		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17, 709, 740		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	49, 937, 500	0	0	U	36.00
37. 00	Accounts payable	971, 797	·l ol	0	0	37.00
38. 00	Sal ari es, wages, and fees payable	1, 539, 358		0	0	38.00
39. 00	Payrol I taxes payable	0	Ö	0	0	
40.00	Notes and Loans payable (short term)	1, 053, 734	. 0	0	0	40.00
41.00	Deferred income	106, 568	0	0	0	41.00
42.00	Accel erated payments	0	)			42.00
43.00	Due to other funds	250, 000		0	0	43.00
44. 00	Other current liabilities	0		0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	3, 921, 457	0	0	0	45.00
46. 00	Mortgage payable	5, 050, 000	ol	0	0	46.00
47. 00	Notes payable	32, 616, 250		0	0	
48. 00	Unsecured Loans	02,010,200		0	0	
49. 00	Other long term liabilities	667, 872		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	38, 334, 122	. 0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42, 255, 579	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	7, 681, 921				52.00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted			0		54. 00 55. 00
56.00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant			O	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
- ==	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	7, 681, 921		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	49, 937, 500	0	0	0	60.00
	[59]	I	1			I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MIDWEST MEDICAL CENTER In Lieu of Form CMS-2552-10

Period: Worksheet G-1 From 10/01/2022 Provider CCN: 14-1302

					To 09/30/2023		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) CHANGE IN NET ASSETS  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	0 56, 709 0 0 0 0	2.00 6, 089, 052 1, 536, 160 7, 625, 212 56, 709 7, 681, 921		4.00 0 0 0 0 0 0 0 0 0 0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7, 681, 921		0		19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) CHANGE IN NET ASSETS	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1302

			To	09/30/2023	Date/Time Pre 2/23/2024 11:0	
	Cost Center Description	Inpa	ati ent	Outpati ent	Total	o, an
			. 00	2.00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>			
	General Inpatient Routine Services					
1.00	Hospi tal	2	, 161, 203		2, 161, 203	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER		0		0	4.00
5.00	Swing bed - SNF	1	, 270, 480		1, 270, 480	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	•	, 237, 764		4, 237, 764	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	7	, 669, 447		7, 669, 447	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)	inco	0		0	15. 00 16. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	rnes	0		U	16.00
17. 00	11-15)  Total inpatient routine care services (sum of lines 10 and 16)	7	, 669, 447		7, 669, 447	17. 00
18.00	Ancillary services		, 680, 637	28, 840, 066	32, 520, 703	18.00
19. 00	Outpati ent servi ces		2, 192	4, 038, 054	4, 040, 246	19. 00
20. 00	RURAL HEALTH CLINIC		2, 1,2	2, 192, 669	2, 192, 669	
20. 01	RURAL HEALTH CLINIC II		0	672, 548	672, 548	20. 01
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0,2,0.0	0/2/0/0	21. 00
22. 00	HOME HEALTH AGENCY			Š	ŭ,	22.00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	PROFESSI ONAL FEES		429, 891	6, 136, 698	6, 566, 589	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 t	o Wkst. 11	, 782, 167	41, 880, 035	53, 662, 202	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			35, 805, 274		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00	PROVISION FOR BAD DEBTS		498, 141			31.00
32. 00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00	T-1-1 - 11:11:00 (- 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0		0	400 444		35.00
36.00	Total additions (sum of lines 30-35)		0	498, 141		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39.00			-			39.00
40. 00 41. 00			0			40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)		U			41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		36, 303, 415		42.00
45.00	to Wkst. G-3, line 4)	( trails) el		30, 303, 413		+3.00
	10 1100 17	ı	I	ı		

	Financial Systems MIDWEST MEDICAL			u of Form CMS-2			
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 14-1302	Peri od: From 10/01/2022	Worksheet G-3			
	To 09/30/2023						
				2/23/2024 11:	09 am		
				1. 00			
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		53, 662, 202	1.00		
2.00	Less contractual allowances and discounts on patients' accour	nts		19, 400, 660	2.00		
3.00	Net patient revenues (line 1 minus line 2)			34, 261, 542			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		36, 303, 415			
5. 00	Net income from service to patients (line 3 minus line 4)			-2, 041, 873	5.00		
	OTHER I NCOME		1	100.001			
6. 00	Contributions, donations, bequests, etc			130, 334			
7. 00 8. 00	Income from investments			467, 983 0			
9. 00	Revenues from telephone and other miscellaneous communication Revenue from television and radio service	i services		0			
10.00	Purchase di scounts			0			
11. 00	Rebates and refunds of expenses			0			
12. 00	Parking lot receipts			0			
13. 00	Revenue from Laundry and Linen service			0			
14.00	Revenue from meals sold to employees and guests			212, 459			
15.00	Revenue from rental of living quarters			0	15. 00		
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00		
17. 00	Revenue from sale of drugs to other than patients			0			
18. 00				1, 099	1		
19. 00				0			
20.00	3			0			
21. 00	Rental of vending machines			0	21.00		
22. 00	Rental of hospital space			18, 440	1		
23. 00 24. 00	Governmental appropriations			0 1, 531, 191			
24. 00	340B REVENUE   ASSISTED LIVING UNITS			806, 534	1		
24. 01	MISCELLANEOUS REVENUE			77, 110	1		
24. 02				176, 243			
24. 04	GRANT REVENUE			162, 166			
24. 05	OTHER (SPECIFY)			0	1		
24. 06	1			0			
24.50	COVI D-19 PHE Fundi ng			0	24. 50		
25.00	Total other income (sum of lines 6-24)			3, 583, 559	25. 00		
26. 00				1, 541, 686			
27. 00				5, 526			
27. 01				0			
28. 00	the second secon			5, 526			
29. 00	Net income (or loss) for the period (line 26 minus line 28)			1, 536, 160	29.00		

Heal th	Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/23/2024 11:	
					RHC I	Cost	<u> </u>
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 137, 161	0		·		1.00
2.00	Physician Assistant	0	0		0 7 200	0	2.00
3.00	Nurse Practitioner	140, 930	0	140, 93	7, 328		
4.00	Visiting Nurse	242 025	0	242.02	0	0	4.00
5.00	Other Nurse	343, 925 0	0	343, 92		343, 925 0	1
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	O O	0		0 0		6. 00 7. 00
8. 00	Laboratory Techni ci an	0	0			0	8.00
9. 00	Other Facility Health Care Staff Costs	0	44, 347	44.34	7 -12, 277	1	
10.00	Subtotal (sum of lines 1 through 9)	1, 622, 016	44, 347	1, 666, 36			10.00
11. 00	Physician Services Under Agreement	1, 022, 010	44, 347		0 -31, 477	1,014,004	11.00
12. 00	Physician Supervision Under Agreement	ol Ol	0			Ö	12.00
13. 00	Other Costs Under Agreement	ol	0			o o	13.00
14. 00	Subtotal (sum of lines 11 through 13)	ol	0			o o	14.00
15. 00	Medi cal Supplies	ol	119, 015	119, 01	5 0	119, 015	
16.00	Transportation (Health Care Staff)	o	0		0	0	ı
17.00	Depreciation-Medical Equipment	o	0		0 0	0	17.00
18.00	Professional Liability Insurance	o	0		0	0	18.00
19.00	Other Health Care Costs	o	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	119, 015			119, 015	
22.00	Total Cost of Health Care Services (sum of	1, 622, 016	163, 362	1, 785, 37	-51, 479	1, 733, 899	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	ما					
23. 00	Pharmacy	0	0		0		
24. 00	Dental	0	0		0 0	1	
25. 00 25. 01	Optometry Telehealth	U O	0		0 0	0	25.00
25. 01	Chronic Care Management	U O	0		0 0	0	25.01
26. 00	All other nonreimbursable costs	O O	0		0 0	0	26.00
27.00	Nonallowable GME costs	٩	U		0	U	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	
20.00	through 27)	٩	0				20.00
	FACILITY OVERHEAD				·		1
29. 00	Facility Costs	ol	0		0 0	0	29. 00
30.00	Administrative Costs	235, 728	70, 486		-		
31. 00	Total Facility Overhead (sum of lines 29 and		70, 486				1
	30)			•			

1, 857, 744

233, 848

-51, 479

2, 040, 113

32.00

2, 091, 592

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	MIDWEST MEDI	CAL CENTER		Inlie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	INI DWEST INEDI		CN: 14-1302	Peri od:	Worksheet M-1	
		Component	CCN: 14-8511	From 10/01/2022 To 09/30/2023		
				RHC I	Cost	
	Adjustments	Net Expenses				
		for				

					2/23/2024 11:09 am
				RHC I	Cost
	·	Adjustments	Net Expenses		
		,	for l		
			Allocation		
			(col. 5 +		
			l ,		
		,	col . 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	-42, 256	1, 048, 375		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	148, 258		3.00
4.00	Visiting Nurse	0	0		4.00
5. 00	Other Nurse	0	343, 925		5.00
6. 00	Clinical Psychologist	0	343, 723		6.00
		0	۱		
7. 00	Clinical Social Worker	0	0		7.00
8. 00	Laboratory Techni ci an	0	0		8. 00
9.00	Other Facility Health Care Staff Costs	0	32, 070		9.00
10.00	Subtotal (sum of lines 1 through 9)	-42, 256	1, 572, 628		10.00
11.00	Physician Services Under Agreement	0	ol		11.00
12.00		0	l ol		12.00
13. 00	,	0	ا		13.00
14. 00		0	Ö		14.00
	,	0	- 1		
15. 00	Medical Supplies	0	119, 015		15. 00
16. 00		0	0		16. 00
17. 00		0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	o		19.00
20.00	Allowable GME Costs				20.00
21. 00		0	119, 015		21.00
22. 00	Total Cost of Health Care Services (sum of	-42, 256			22.00
22.00		-42, 230	1,071,043		22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES	_			
23. 00		0	١		23. 00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25. 01	Tel eheal th	0	o		25. 01
25. 02	Chronic Care Management	0	l ol		25. 02
26. 00	9	0	ام		26.00
27. 00		J	Ĭ		27.00
		0	0		
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	١		28. 00
	through 27)				
	FACILITY OVERHEAD		T		
	Facility Costs	0	0		29. 00
30.00	Administrative Costs	0	306, 214		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	306, 214		31.00
	30)				
32.00	Total facility costs (sum of lines 22, 28	-42, 256	1, 997, 857		32.00
52. 50	and 31)	.2, 200	',,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		32.00
	14.14 5.7	ļ	ı		ı

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	MI DWEST MEDI	CAL CENTER Provider C	CN: 14-1302	<u> </u>	u of Form CMS-: Worksheet M-1	
					From 10/01/2022 To 09/30/2023		pared:
					RHC II	Cost	07 dili
		Compensation	Other Costs	Total (col. 1	Reclassi fi cat	Reclassi fi ed	
				+ col . 2)	ions	Trial Balance	
				,		(col. 3 +	
						col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	308, 571	0	308, 57	1 34, 835	343, 406	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	33, 016	0	33, 01	6 0	33, 016	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	161, 460	0	161, 46	0	161, 460	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	21, 263	21, 26	3 0	21, 263	9.00
10.00	Subtotal (sum of lines 1 through 9)	503, 047	21, 263	524, 31	34, 835	559, 145	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	21, 049	21, 04	9 0	21, 049	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21, 049	21, 04	9 0	21, 049	21.00
22.00	Total Cost of Health Care Services (sum of	503, 047	42, 312	545, 35	9 34, 835	580, 194	22.00
	lines 10, 14, and 21)						]
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	0		0	0	
24. 00	Dental	0	0		0	0	24.00
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	3	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						1
	Facility Costs	0	7, 923			7, 923	1
	Administrative Costs	55, 147	21, 554			87, 614	
31 ∩∩	Total Facility Overhead (sum of lines 20 and	55 1/17	20 /77	8/1 62	10 013	05 527	31 00

55, 147

558, 194

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

84, 624

629, 983

29, 477

71, 789

7, 923 87, 614 95, 537

675, 731

10, 913

45, 748

31.00

32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS  Provider CCN: 14-1302   Period:   From 10/01/2022	Worksheet M-1
Component CCN: 14-8557   To   09/30/2023   [	

			Component CCN: 14-8557	10	09/30/2023	2/23/2024 11:	
					RHC II	Cost	O7 dill
		Adjustments	Net Expenses			3001	
		riaj do timorreo	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	343, 406				1.00
2.00	Physici an Assistant	o	o				2.00
3.00	Nurse Practitioner	o	33, 016				3.00
4.00	Visiting Nurse	o	o				4.00
5.00	Other Nurse	o	161, 460				5.00
6.00	Clinical Psychologist	o	o				6.00
7.00	Clinical Social Worker	o	ol				7.00
8.00	Laboratory Techni ci an	o	ol				8.00
9.00	Other Facility Health Care Staff Costs	O	21, 263				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	559, 145				10.00
11. 00	Physician Services Under Agreement	0	ol				11.00
12.00	Physician Supervision Under Agreement	0	ol				12.00
	Other Costs Under Agreement	0	ol				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	ol				14.00
15. 00	Medical Supplies	0	21, 049				15.00
16. 00	Transportation (Health Care Staff)	0	0				16.00
	Depreciation-Medical Equipment	0	ol				17. 00
18.00	Professional Liability Insurance	0	ol				18. 00
19.00	Other Health Care Costs	0	ol				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21, 049				21.00
22. 00	Total Cost of Health Care Services (sum of	0	580, 194				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		'				
23.00	Pharmacy	0	0				23. 00
24.00	Dental	0	o				24.00
25.00	Optometry	0	o				25.00
25. 01	Tel eheal th	0	o				25. 01
25.02	Chronic Care Management	O	o				25. 02
26.00	All other nonreimbursable costs	o	o				26. 00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	o				28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	7, 923				29. 00
30.00	Administrative Costs	-2, 500	85, 114				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-2, 500	93, 037				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-2, 500	673, 231				32.00
	and 31)						

	Financial Systems	MIDWEST MEDI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/23/2024 11:	
					RHC I	2/23/2024 TT.	U9 alli
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel	lotal visits	Standard (1)	Visits (col.	col. 2 or	
				oranida (1)	1 x col . 3)	col . 4	
		1. 00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1					
	Posi ti ons						İ
1.00	Physi ci an	2. 69	7, 828	2, 91	0 7, 828		1.00
2.00	Physician Assistant	0.00	0	2, 10	o o		2.00
3.00	Nurse Practitioner	0. 96	2, 130	2, 10	0 2, 016		3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 65	9, 958		9, 844	9, 958	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	3. 65	9, 958			9, 958	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						1. 00	
10.00	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		4 (04 (40	10.00
	Total costs of health care services (from Wk					1, 691, 643	
11.00	,					0	11.00
12.00	Cost of all services (excluding overhead) (s					1, 691, 643	
13.00	Ratio of hospital -based RHC/FQHC services (I			24)		1.000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		306, 214	
15.00	Parent provider overhead allocated to facili	ty (see Instru	Ctions)			1, 143, 349	
16.00	Total overhead (sum of lines 14 and 15)					1, 449, 563	
17.00	Allowable GME overhead (see instructions)					1 440 543	17. 00 18. 00
	Enter the amount from line 16	NIC comit con (I	ino 12 v lino	10)		1, 449, 563	
	Overhead applicable to hospital based RHC/FC					1, 449, 563	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	unc services (	Sum of fines f	u anu 19)		3, 141, 206	<sub>1</sub> 20.00

	Financial Systems	MIDWEST MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
			Component	0014: 11 0007	10 077 007 2020	2/23/2024 11:	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions			1			
1.00	Physi ci an	0. 43					1.00
2. 00	Physician Assistant	0.00					2.00
3. 00	Nurse Practitioner	0. 27					3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 70			2, 373	3, 343	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	0.00	0			0	7. 02
8. 00	only)	0.70	2 242			2 242	8.00
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0. 70	3, 343			3, 343	8.00
9. 00	Physician Services Under Agreements		0			0	9.00
9.00	Physician services under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASI	ED RHC/FOHC SEL	RVLCES		1. 00	
	Total costs of health care services (from Wk					580, 194	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12. 00	Cost of all services (excluding overhead) (s					580, 194	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			i ne 31)		93, 037	
15. 00	Parent provider overhead allocated to facili			,		221, 509	
16.00	Total overhead (sum of lines 14 and 15)	,	,			314, 546	
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					314, 546	18.00
19.00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		314, 546	19.00
	Total allowable cost of hospital-based RHC/F					894, 740	20 00

Heal th	Financial Systems MIDWEST MEDICAL	CENTER	Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI C		Component CCN: 14-8511	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		Title XVIII	RHC I	2/23/2024 11:	09 am_
		IT THE AVITE	KHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · · · · · · · · · · · · · · ·		3, 141, 206	•
2.00	Cost of injections/infusions and their administration (from W			76, 017	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m	irnus irne 2)		3, 065, 189 9, 958	
5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		9, 936	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	11 He 7)		9, 958	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			307. 81	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	4 or your contractor)	1. 00 356. 56	2. 00 370. 10	8.00
9. 00	Rate for Program covered visits (see instructions)	. 6 or your contractor)	307. 81	307. 81	9.00
7. 00	CALCULATION OF SETTLEMENT		307.01	307.01	7.00
10.00	Program covered visits excluding mental health services (from	contractor records)	573	1, 949	10.00
11.00	Program cost excluding costs for mental health services (line	9 x line 10)	176, 375	599, 922	11.00
12.00	Program covered visits for mental health services (from contr	•	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	•	0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	776, 297	
16. 01	Total program charges (see instructions) (from contractor's re	•		558, 175	
16. 02	Total program preventive charges (see instructions) (from prov			36, 918	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		51, 345	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		542, 070	16. 04
14 OE	(Titles V and XIX see instructions.)		0	EO2 41E	14 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		U	593, 415 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		47, 364	1
	records)	,		,	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		94, 495	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			593, 415	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		20, 632	
22.00	Total reimbursable Program cost (line 20 plus line 21)	•		614, 047	22.00
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst SEQUESTRATION	ructions)		0	24. 00 25. 00
	Pioneer ACO demonstration payment adjustment (see instruction	(2)		0	
25. 99	Demonstration payment adjustment amount before sequestration	·~,		0	
26. 00	, , , , , , , , , , , , , , , , , , , ,			614, 047	1
26. 01	Sequestration adjustment (see instructions)			12, 281	
26. 02	, , , , , , , , , , , , , , , , , , , ,			0	
27. 00	Interim payments			459, 322	
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 29)		142 444	28.00
29. 00 30. 00	, , ,			142, 444 0	29. 00 30. 00
30.00	chapter I, §115.2	mee with ome rub. 19-11	'		30.00
	, , , , , , , , , , , , , , , , , , , ,		'		

Heal th Financial Systems
SERVICES   Component CCN: 14-8557   From 10/01/2022   Date/Time Prepared: 2/23/2024 11: 09 am
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   Total Allowable Cost of hospital -based RHC/FOHC Services (from Wkst. M-2, line 20)   894,740   1.00   2.00   3.00   Total allowable cost excluding injections/infusions (line 1 minus line 2)   880,733   3.00   4.00   Total visits (from Wkst. M-2, column 5, line 8)   3,343   4.00   7.00   New York of the State of the S
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   1.00   Total Allowable Cost of hospital -based RHC/FOHC Services (from Wkst. M-2, line 20)   894,740   1.00   2.00   3.00   Total allowable cost excluding injections/infusions (line 1 minus line 2)   880,733   3.00   4.00   Total visits (from Wkst. M-2, column 5, line 8)   3,343   4.00   7.00   New York of the Services (line 1 minus line 2)   880,733   3.00   1.00   New York of the Services (line 2 minus line 2)   880,733   3.00   1.00   New York of the Services (line 3 minus line 2)   8.00   New York of the Services (line 4 plus line 5)   0.00   0.
1.00   Total Allowable Cost of hospital -based RHC/FOHC Services (from Wkst. M-2, line 20)   894,740   1.00   2.00   Cost of injections/infusions and their administration (from Wkst. M-4, line 15)   14,007   2.00   4.00   Total allowable cost excluding injections/infusions (line 1 minus line 2)   880,733   3.00   4.00   Total Visits (from Wkst. M-2, column 5, line 8)   3,343   4.00   5.00   Physicians visits under agreement (from Wkst. M-2, column 5, line 9)   0   5.00   7.00   Adjusted visits (line 4 plus line 5)   263.46   7.00   Adjusted cost per visit (line 3 divided by line 6)   263.46   7.00   Calculation of Limit (1)   Rate Period 1   Rate Period 2   (10/01/2022   through 12/31/2022)   99/30/2023   1.00   2.00   Program covered visits (see instructions)   263.46   26
2.00   Cost of injections/infusions and their administration (from Wkst. M-4, line 15)   14,007   2.00   3.00   Total allowable cost excluding injections/infusions (line 1 minus line 2)   880,733   3.00   5.00   Total Visits (from Wkst. M-2, column 5, line 8)   3,343   4.00   5.00   Physicians visits under agreement (from Wkst. M-2, column 5, line 9)   0,5.00   7.00   Adjusted cost per visit (line 4 plus line 5)   263.46   7.00   7.00   Adjusted cost per visit (line 3 divided by line 6)   263.46   7.00   Calculation of Limit (1)   Rate Period 1 (10/01/2022 through 12/31/2022)   1.00   2.0
3.00   Total allowable cost excluding injections/infusions (line 1 minus line 2)   880, 733   3.00   4.00   Total Visits (from Wkst. M-2, column 5, line 8)   3,343   4.00   5.00   Total adjusted visits under agreement (from Wkst. M-2, column 5, line 9)   0   0.00   7.00   Total adjusted visits (line 4 plus line 5)   3,343   6.00   7.00   Adjusted cost per visit (line 3 divided by line 6)   263.46   7.00   Calculation of Limit (1)   Rate Period 1   (10/01/2022   through through through 12/31/2022)   09/30/2023)   1.00   2.00   Rate for Program covered visits (see instructions)   263.46   2
S. 00   Physicians visits under agreement (from Wkst. M-2, column 5, line 9)   0   5. 00
Total adjusted visits (line 4 plus line 5)   3,343   6.00   7.00   Adjusted cost per visit (line 3 divided by line 6)   263.46   7.00
Adjusted cost per visit (line 3 divided by line 6)   263.46   7.00
Calculation of Limit (1)   Rate Period 1
Rate Peri od 1 (10/01/2022 through 12/31/2022)   Through 12/31/2
10/01/2022 through 12/31/2022)   09/30/2023 through 12/31/2022)   09/30/2023   09/30/2023   1.00   2.00
through   12/31/2022)   09/30/2023)     1.00   2.00
12/31/2022)   09/30/2023
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)  9.00 Rate for Program covered visits (see instructions)  10.00 Program covered visits excluding mental health services (from contractor records)  10.00 Program covered visits excluding mental health services (line 9 x line 10)  11.00 Program covered visits for mental health services (from contractor records)  12.00 Program covered visits for mental health services (from contractor records)  13.00 Program covered cost from mental health services (line 9 x line 10)  13.00 Program covered cost from mental health services (line 9 x line 12)  13.00 Program covered cost from mental health services (line 9 x line 12)  14.00 Limit adjustment for mental health services (see instructions)  15.00 Graduate Medical Education Pass Through Cost (see instructions)
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)  9.00 Rate for Program covered visits (see instructions)  10.00 Program covered visits excluding mental health services (from contractor records)  11.00 Program covered visits for mental health services (line 9 x line 10)  12.00 Program covered visits for mental health services (from contractor records)  13.00 Program covered visits for mental health services (from contractor records)  13.00 Program covered cost from mental health services (line 9 x line 12)  14.00 Limit adjustment for mental health services (see instructions)  15.00 Graduate Medical Education Pass Through Cost (see instructions)
9.00Rate for Program covered visits (see instructions)263.46263.469.00CALCULATION OF SETTLEMENT10.00Program covered visits excluding mental health services (from contractor records)13346610.0011.00Program cost excluding costs for mental health services (line 9 x line 10)35,040122,77211.0012.00Program covered visits for mental health services (from contractor records)0012.0013.00Program covered cost from mental health services (line 9 x line 12)0013.0014.00Limit adjustment for mental health services (see instructions)0014.0015.00Graduate Medical Education Pass Through Cost (see instructions)15.00
10.00 Program covered visits excluding mental health services (from contractor records) 11.00 Program cost excluding costs for mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (from contractor records) 13.00 Program covered cost from mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (see instructions) 10.00 11.00 12.772 11.00 12.00 13.00 14.00 15.00 Graduate Medical Education Pass Through Cost (see instructions) 133 466 10.00 122,772 11.00 12.00 12.00 13.00 15.00
11.00 Program cost excluding costs for mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (from contractor records) 13.00 Program covered cost from mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (see instructions) 15.00 Graduate Medical Education Pass Through Cost (see instructions) 11.00 12.772 11.00 12.00 12.00 13.00 14.00 15.00
12.00 Program covered visits for mental health services (from contractor records) 13.00 Program covered cost from mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (see instructions) 15.00 Graduate Medical Education Pass Through Cost (see instructions) 10 0 12.00 13.00 14.00 15.00
13.00 Program covered cost from mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (see instructions) 0 0 13.00 15.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00
14.00Limit adjustment for mental health services (see instructions)0014.0015.00Graduate Medical Education Pass Through Cost (see instructions)15.00
15.00 Graduate Medical Education Pass Through Cost (see instructions) 15.00
4, 00   T   1   D
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 0 157,812 16.00
16.01 Total program charges (see instructions)(from contractor's records) 117,581 16.01
16.02 Total program preventive charges (see instructions)(from provider's records)  4,257 16.02  16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16)  5,714 16.03
16.03 Total Program non-preventive costs ((Tine 16.02/Tine 16.03 and 18) times .80)
(Titles V and XIX see instructions.)
16.05 Total program cost (see instructions) 0 118,192 16.05
17.00 Primary payer amounts 0 17.00
18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 11,500 18.00
records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 20,055 19.00
records)
20.00 Net Medicare cost excluding vaccines (see instructions) 118,192 20.00
21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 2,398 21.00
22.00 Total reimbursable Program cost (line 20 plus line 21)
23.00   Allowable bad debts (see instructions) 0   23.00   23.01   Adjusted reimbursable bad debts (see instructions) 0   23.01
23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  0 23.01  24.00
25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)
25.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 25.50
25.99 Demonstration payment adjustment amount before sequestration 0 25.99
26.00 Net reimbursable amount (see instructions) 120,590 26.00
26.01 Sequestration adjustment (see instructions) 2, 412 26.01
26.02 Demonstration payment adjustment amount after sequestration 0 26.02 27.00 Interim payments 112,486 27.00
28. 00   Tentative settlement (for contractor use only)   112,460   27.00   28.00   27.00   28.00
29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 5,692 29.00
30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 0 30.00
chapter   , §115.2

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1302	Peri od: From 10/01/2022	Worksheet M-4	
		Component C	CCN: 14-8511	To 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 572, 628 0. 000684	1, 572, 62 0. 0019		1, 572, 628 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 076	3, 0	13 937	0	3. 0
4. 00	Injections/infusions and related medical supplies costs (from your records)	19, 319	16, 59	93 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	20, 395	19, 60	06 937	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 691, 643	1, 691, 64	1, 691, 643	1, 691, 643	6. 0
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 449, 563	1, 449, 50	1, 449, 563	1, 449, 563	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 012056	0. 01159	0. 000554	0. 000000	8.0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	17, 476	16, 80	00 803	0	9.0
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	37, 871	36, 40	1, 740	0	10.0
11. 00	Total number of injections/infusions (from your records)	156	43	37 136		1
12.00	Cost per injection/infusion (line 10/line 11)	242. 76	83. 3			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	36	1;	36 44	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 739	11, 33	563	0	14.00
					COST OF INJECTIONS /	
					INFUSIONS AND ADMINISTRATIO	
				1.00	N	
5 00	Total cost of injections/infusions and their administration	n costs (sum of	Columns 1	1. 00	2. 00 76, 017	15.0
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)				
6.00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of		20, 632	16. C

	Financial Systems MIDWEST MEDIATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	N: 14-1302	Peri od:	Worksheet M-4	
		Component C	CCN: 14-8557	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/23/2024 11:	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	559, 145 0. 000547	559, 14 0. 00095		559, 145 0. 000000	
. 00	Injection/infusion health care staff cost (line 1 x line 2)	306	53	0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	5, 486	2, 75	56 0	0	4.0
. 00	Direct cost of injections/infusions (line 3 plus line 4)	5, 792	3, 29	91 0	0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	580, 194	580, 19	·	580, 194	
. 00	Total overhead (from Wkst. M-2, line 19)	314, 546	314, 54		314, 546	
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 009983	0. 00567		0. 000000	
. 00	Overhead cost - injection/infusion (line 7 x line 8)	3, 140	1, 78		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8, 932	5, 07		0	
1.00	Total number of injections/infusions (from your records)	40		70 0	0	
2. 00	Cost per injection/infusion (line 10/line 11)	223. 30	72. 5			12.0
3.00	Number of injection/infusion administered to Program beneficiaries	1	3	0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	223	2, 17	75 0	0	14.0
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1.00	N	
- 00	Total good of injections /infections and their administration	n costo (our of	Coolumno 1	1. 00	2.00	15 /
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			14, 007	15. (
5 00	Total Program cost of injections/infusions and their admin	istration costs	(SUM OF		2, 398	16

Health Financial Systems	MIDWEST MEDICA	AL CENTER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/ SERVICES RENDERED TO PROGRAM BENEFICIARIES	FOHC PROVIDER FOR	Provider CCN: 14-1302 Component CCN: 14-8511	From 10/01/2022	
			DUC I	C+

				2/23/2024 11: 0	09 ar
			RHC I	Cost	
		<u> </u>	Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
.00	Total interim payments paid to hospital-based RHC/FQHC			524, 853	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				o	3.
03				O	3.
04				o	3.
05				0	3
	Provider to Program		<u> </u>		
50			05/08/2023	65, 531	3
51				0	3
52				0	3
3				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		-65, 531	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			459, 322	4
00	27)	orer to worksheet in o, Title		107, 022	l '
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date of	F		5
	each payment. If none, write "NONE" or enter a zero. (1)	sic review. All se shew date e			ľ
	Program to Provider				
21	g			0	5
02				o	5
)3				0	5
-	Provider to Program				
50	, , , , , , , , , , , , , , , , , , ,			0	5
51				0	5
52				o	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			142, 444	6
)2	SETTLEMENT TO PROGRAM			142, 444	6
00	Total Medicare program liability (see instructions)			601, 766	7
	Total modificate program trabitity (See Tristractions)		Contractor	NPR Date	<u> </u>
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	

Health Financial Systems	MIDWEST MEDICAL	CENTER		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1: Component CCN: 14-8	Fro	m 10/01/2022	Worksheet M-5  Date/Time Prepared: 2/23/2024 11:09 am

		Component CCN: 14-8557	10 09/30/2023	2/23/2024 11: 0	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			116, 969	1.
	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.
	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider				3.
	riogialii to riovidei			0	3.
01 02				0	3.
03				0	3.
04				0	3.
)5	D			0	3
	Provider to Program		05 (00 (0000	4 400	_
0			05/08/2022	4, 483	3
1				0	3
2				0	3
3				0	3
4				0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-4, 483	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	9	112, 486	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		-1		_
	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5
	Program to Provider				
)1				0	5
)2				0	5
3				0	5
. t	Provider to Program				
0				0	5
1				0	5
2				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
	SETTLEMENT TO PROVIDER			5, 692	6
2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			118, 178	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	
		U	1.00	2.00	