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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0002 Worksheet S Period: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/25/2020 8: 03 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 or "L" for low. 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(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 the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) MATTHEW DOYLE
Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	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	1, 006, 597	-215, 772	0	-1, 156, 846	1.00
2.00	Subprovi der - IPF	0	4, 010	0		0	2.00
3.00	Subprovi der - I RF	0	28, 927	2		55, 210	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	1, 039, 534	-215, 771	0	-1, 101, 636	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

22. 00	Does this facility qualify and is it currently receing disproportionate share hospital adjustment, in accors 412.106? In column 1, enter "Y" for yes or "N" for facility subject to 42 CFR Section §412.106(c)(2)(Pi	dance with no. Is thi	42 CFR s	Y	N	ı		22.00
22. 01	hospital?) In column 2, enter "Y" for yes or "N" for Did this hospital receive interim uncompensated care cost reporting period? Enter in column 1, "Y" for ye the portion of the cost reporting period occurring p	payments f s or "N" fo	r no for	Υ	١	′		22. 01
22. 02	Enter in column 2, "Y" for yes or "N" for no for the reporting period occurring on or after October 1. (s Is this a newly merged hospital that requires final payments to be determined at cost report settlement?	portion of ee instruct uncompensat	the cost ions) ed care	N	N	1		22. 02
	Enter in column 1, "Y" for yes or "N" for no, for the cost reporting period prior to October 1. Enter in c or "N" for no, for the portion of the cost reporting October 1.	e portion c olumn 2, "Y	of the " for yes					
22. 03	Did this hospital receive a geographic reclassificat rural as a result of the OMB standards for delineati adopted by CMS in FY2015? Enter in column 1, "Y" for	ng statisti	cal areas	N	N	ı	N	22. 03
	for the portion of the cost reporting period prior t in column 2, "Y" for yes or "N" for no for the porti reporting period occurring on or after October 1. (s	on of the c	ost					
	Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter in yes or "N" for no.							
23. 00	P P				3 1	ı		23.00
		In-State	In-State	Out-of	Out-of	Medi cai d		
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO days	Medi cai d days	
			unpai d	pai d days	eligible		,-	
		1 00	days	0.00	unpai d			_
24 00	If this provider is an IPPS hospital, enter the	1. 00 3. 148	2. 00 6, 113	3. 00 556	4. 00 728	5. 00 14. 46	6.00	24.00
24.00	in-state Medicaid paid days in column 1, in-state	3, 140	0, 113	330	720	14, 40		24.00
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
MCRI F3	2 - 16. 1. 168. 0							

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-25	52-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 15-0002  Period: Worksheet S-2 From 01/01/2019 Part I	
To 12/31/2019 Date/Time Prepa 6/25/2020 8:03	
In-State   In-State   Out-of   Out-of   Medicaid   Other	Cili
Medicaid   Medicaid   State   State   HMO days   Medicaid   paid days   eligible   Medicaid   Medicaid   days	
unpaid paid days eligible	
days   unpai d	
25.00   f this provider is an IRF, enter the in-state 139 301 0 0 569 2	25. 00
Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2,	
out-of-state Medicaid days in column 3, out-of-state	
Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	
Urban/Rural S Date of Geogr	
26. 00 Enter your standard geographic classification (not wage) status at the beginning of the	26. 00
cost reporting period. Enter "1" for urban or "2" for rural.	27.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,	27. 00
enter the effective date of the geographic reclassification in column 2.	35. 00
effect in the cost reporting period.	
Beginning:   Ending:	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	36. 00
of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status	37. 00
is in effect in the cost reporting period.	
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see	37. 01
i nstructi ons)	
38.00   If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is   3   3   3   3   3   3   3   3   3	38. 00
enter subsequent dates.	
Y/N Y/N 1.00 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N	39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in	
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes	
or "N" for no. (see instructions) 40.00   Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or N N N	40. 00
"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	
V XVIII XIX	
Prospective Payment System (PPS)-Capital	
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N Y N	45. 00
with 42 CFR Section §412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances  N N N N V	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through	.0.00
Pt. III. 47.00  s this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N 4	47. 00
48.00 <u>Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N</u>	48. 00
Teaching Hospitals  56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or Y N S	56. 00
"N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA	
GME payment reduction? Enter "Y" for yes or "N" for no in column 2.  57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved N .	57. 00
GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"	
for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is	
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as  N   58.00   59	58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. Ď-5.	
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. N September 1. N September 1. N September 2. NAHE 413.85 Worksheet A Pass-Through	59. 00
Y/N Line # Qualification	
Criterion Code	
1.00 2.00 3.00	10.05
60.00 Are you claiming nursing and allied health education (NAHE) costs for Y N Any programs that meet the criteria under 42 CFR 413.85? (see	60. 00
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 adjustement? Enter "Y" for yes or "N" for no in column 2.	
	60. 01
pristractions)	

Health Financial Systems METHODI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		PITALS, INC Provider C		Peri od: From 01/01/2019	worksheet S-2 Part I	
				To 12/31/2019	6/25/2020 8: 0	
	Y/N	IME	Direct GME	I ME	Direct GME	
51.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3.00	4. 00	5. 00	61.0
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 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	14			0.00	0.00	61.0
<ul> <li>1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)</li> <li>1.03 Enter the base line FTE count for primary care</li> </ul>						61.0
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or						61.0
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).  Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  Enter the amount of ACA §5503 award that is being						61.0
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 1
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.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 2
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruction).  2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the property of the pr	ctions) n Teach gram. (	ing Health Cer see instructio	nter (THC) int			62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this d			N	63.0
		ŭ.	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No.			!			
period that begins on or after July 1, 2009 and before 24.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trai n-prima all no I non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0. (	0.00	0. 000000	64.0

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0002 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 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. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/(col. 3 +Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 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)

	1.00	2.00	3. 00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider	? Y			70.00
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	N	N	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	Y			75.00
subprovider? Enter "Y" for yes and "N" for no.				

ealth Financial Systems METHODIST HOSE OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PITALS, INC Provider CCN: 15-0002	Peri od:	worksheet S-	2
		From 01/01/2019 To 12/31/2019		
		1. (		
6.00 If line 75 is yes: Column 1: Did the facility have an approrecent cost reporting period ending on or before November 1 no. Column 2: Did this facility train residents in a new te CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no indicate which program year began during this cost reportin	5, 2004? Enter "Y" for yes aching program in accordar . Column 3: If column 2 is	s or "N" for nce with 42 s Y,	N O	76. 0
Long Term Care Hospital PPS			1. 00	1—
D.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.  TEFRA Providers		ng period? Ente	N N	80. 0 81. 0
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i 6.00 Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under 42 CFR Sect	i on		85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospit   1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified under sectio		N	87.0
		1. 00	XI X 2. 00	-
Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospit	al comidação Entan "V" for		Y	90.0
yes or "N" for no in the applicable column.  1.00 Is this hospital reimbursed for title V and/or XIX through		N	Y	91.0
full or in part? Enter "Y" for yes or "N" for no in the app 2.00 Are title XIX NF patients occupying title XVIII SNF beds (d	licable column.		N	92. (
instructions) Enter "Y" for yes or "N" for no in the applic 3.00 Does this facility operate an ICF/IID facility for purposes		- N	N	93. (
"Y" for yes or "N" for no in the applicable column.  4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no in the	N	N	94. (
5.00   If line 94 is "Y", enter the reduction percentage in the ap 6.00   Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.		0. 00 N	0. 00 N	95. ( 96. (
7.00 If line 96 is "Y", enter the reduction percentage in the ap Does title V or XIX follow Medicare (title XVIII) for the istepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	nterns and residents post	0. 00 Y	0. 00 Y	97. ( 98. (
3.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	98.
B. 02 Does title V or XIX follow Medicare (title XVIII) for the country bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.		Y	Y	98.
3.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y	tical access hospital (CAF es or "N" for no in columr	1) N	N	98.
for title V, and in column 2 for title XIX.  3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.		N nd	N	98.
3.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	98.
B.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 colum column 2 for title XIX.  Rural Providers	-	Y	Y	98.
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all	-inclusive method of payme	ent N		105. ( 106. (
for outpatient services? (see instructions) 17.00 Column 1: If line 105 is Y, is this facility eligible for c 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 I	n 1. (see instructions) you train I&Rs in an	N		107.
Enter "Y" for yes or "N" for no in column 2. (see instruct		1	1	1

lealth Financial Systems METHODIST HOSF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			eriod: rom 01/01/2019	worksheet S- Part I	
		To			
	Physi cal	Occupati onal	Speech	Respi ratory	
09.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 N	4.00 N	109. 0
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IN .	IN	IN	IN .	109.0
				1. 00	+
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.0
			1.00	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this constant of the response to consintegration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.0
		1.00	2.00	3.00	+
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	period? s "Y", enter he	N	2.00	0.00	112.00
Miscellaneous Cost Reporting Information 15.00 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, I 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	B, or E only) 93" percent (includes	N			0 115. 0
the definition in CMS Pub.15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y"  "N" for no.	for yes or	N			116. 0
17.00   Is this facility legally-required to carry malpractice insu   "Y" for yes or "N" for no.	rance? Enter	Y			117. 0
18.00 s the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occur		1			118.0
IT the portey is craim-made. Enter 2 if the portey is decur-	rence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
18.01 List amounts of malpractice premiums and paid losses:		1, 143, 153			0118.0
			1 00	2.00	_
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheme			1. 00 N	2. 00	118. 02
and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendmented Enter in column 2, "Y" for yes or "N" for no.	n column 1, " ualifies for	Y" for yes or the Outpatient	N	N	119. 00 120. 00
21.00 Did this facility incur and report costs for high cost impla	antable devic	es charged to	Y		121.0
22.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.  Transplant Center Information			N		122. 0
25.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N	" for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		ification date			126. 0
pri corunni i and termination date, ii applicable, ili corunni .	ter the certi	fication date			127. 0
	۷.	C			128. 0
in column 1 and termination date, if applicable, in column 28.00   f this is a Medicare certified liver transplant center, en	ter the certi	fication date			
in column 1 and termination date, if applicable, in column 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 29.00 If this is a Medicare certified lung transplant center, ento	ter the certi 2.				129. 00
128.00 If this is a Medicare certified liver transplant center, en	ter the certi 2. er the certif enter the ce	ication date in			129. 00

Health Financial Systems	METHODI ST HOSI					of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-0002		: 1/01/2019 2/31/2019	Worksheet S- Part I Date/Time Pr 6/25/2020 8:	epared:
					1. 00	2. 00	_
132.00 If this is a Medicare certified is in column 1 and termination date,			cation date		1.00	2. 00	132.00
133.00 Removed and reserved 134.00 If this is an organ procurement of and termination date, if applicable and termination date.		he OPO number i	n column 1				133. 00 134. 00
All Providers  140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. If	yes, and home	office cos	ts	N		140. 00
1.00 If this facility is part of a cha		lines 141 thro	ugh 143 the	name ar	3.00 nd address	of the home	
office and enter the home office of 141.00 Name: 142.00 Street:	Contractor name and contra Contractor's Name: PO Box:	ictor number.	Contrac	tor's Nu	ımber:		141. 00 142. 00
142. 00 Street. 143. 00 Ci ty:	State:		Zi p Cod	e:			143.00
•	•						
144.00Are provider based physicians' co	sts included in Workshoot	M2				1. 00 Y	144.00
144. OUM E PLOVI GEL DASEG PHYSICIALIS CO.	sts included til Molksileet	Λ:				Ť	144.00
					1. 00	2. 00	
145.00  f costs for renal services are clinpatient services only? Enter "Y'no, does the dialysis facility in period? Enter "Y" for yes or "N"	'for yes or "N" for no in clude Medicare utilization for no in column 2.	column 1. If of for this cost	column 1 is reporting		Y N		145. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	n column 1. (See CMS Pub.			lf	IV .		146.00
						1. 00	$\dashv$
147.00 Was there a change in the statist						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	ed cost finding method? E	Part A	es or "N" To Part B		itle V	N Title XIX	149. 00
		1. 00	2. 00		3. 00	4.00	1
Does this facility contain a prov							
or charges? Enter "Y" for yes or 155.00 Hospi tal	'N" for no for each compon	ent for Part A N	and Part B	. (See 4	N N	3. 13) N	155. 00
156.00Subprovi der – TPF		N I	N		N	N	156.00
157.00 Subprovi der - I RF		N	N		N	N	157.00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N I	N		N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N		N N	N N	160. 00 161. 00
TO 1. OU CIVILLE			IN		IN	IV	101.00
Mul +: compus						1. 00	
Multicampus  165.00 Is this hospital part of a Multica  Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more campu	uses in dif	ferent C	BSAs?	N	165. 00
	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00 166. 00
						1.00	
Health Information Technology (HI				ent Act		V	147.00
167.00 s this provider a meaningful user 168.00  f this provider is a CAH (line 10 reasonable cost incurred for the 1	05 is "Y") and is a meanin	gful user (line		"), ente	r the	Υ	167. 00 168. 00
168.01 <mark> f this provider is a CAH and is i</mark>	not a meaningful user, doe	s this provide			dshi p		168. 01
exception under §413.70(a)(6)(ii)′ 169.00 f this provider is a meaningful u					enter the	9 9	99169.00

NC	In Lieu	2552-10	
		Worksheet S-2	
'	0 12/31/2019	6/25/2020 8:0	pareu:
	Reginning		J dill
the reporting	1.00		170.00
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
	1. 00	2. 00	
s enrolled in	N	0	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
he number of section	1		
s	the reporting  enrolled in 2, col. 6? Enter	Period: From 01/01/2019 To 12/31/2019   Beginning	Period: From 01/01/2019   Worksheet S-2   Part I   Date/Time Pre 6/25/2020 8:0

	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	1	Period: From 01/01/2019 To 12/31/2019	Date/Time Pro	epared:
				Y/N	6/25/2020 8:0 Date	)3 am
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter   mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente	er all dates in	the	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to th reporting period? If yes, enter the date of the change in		instructions)			1.00
			1. 00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.		N N	2.00	3.00	2.00
3.00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Type	Date	
	Cinanai al Data and Dananta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av	for Compiled,	Y	A		4.00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5. 00
				Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If you is t	ho providor is	N N	I	6.00
0.00	the legal operator of the program?	ii yes, is t	ne provider is	) IN		0.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y Y		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	Y		9. 00
10.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I&RINANAP		N	Y/N	11.00
					1. 00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents waived? I	fyes, see ins	tructions.	N	14.00
15. 00	Did total beds available change from the prior cost report	Par	t A	Par	t B	15. 00
		1. 00	2. 00	Y/N 3. 00	Date 4. 00	
	PS&R Data		2.00	3.00	1. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/27/2019	Y	03/27/2019	17. 00
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
19. 00	If line 16 or 17 is yes, see Instructions.  Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

Heal th	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (	CCN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pre 6/25/2020 8:0	epared:
		Descr	iption	Y/N	Y/N	
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
	COMPLETED BY COST DELMBURGED AND TEEDA HOODITALC ONLY (EVO	EDT OULL DDENG	HOCDI TALC)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPI CHILDRENS	HUSPITALS)			-
22.00	Capital Related Cost	o i notruoti on			NI NI	22.00
22. 00	Have assets been relifed for Medicare purposes? If yes, se			ring the east	N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	uue to apprai	Sai S illaue uu	iring the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases enter	od into durino	a this cost r	oporting poriod2		24.00
24.00	If yes, see instructions	ca into dui ing	y iiii a Cuat I	cportring perrou!		24.00
25. 00	Have there been new capitalized leases entered into during	the cost reno	orting period	? If ves see		25. 00
_0.00	instructions.	,о обосторс	g por rou	, 555, 566		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ting period?	If yes, see		26.00
	instructions.		3 1	J		
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	fyes, submit		27.00
	copy.			-		
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	uring the cos	t reporting		28. 00
	period? If yes, see instructions.					
29. 00	Did the provider have a funded depreciation account and/or		Debt Service	Reserve Fund)		29. 00
20.00	treated as a funded depreciation account? If yes, see inst					20.00
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with nev	v debt? IT ye	s, see		30.00
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	v deht2 lf ve	992		31.00
31.00	instructions.	33dance of her	v debt: 11 ye	3, 366		31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ned through c	ontractual	N	32.00
	arrangements with suppliers of services? If yes, see instr		3			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to compet	itive bidding? If	N	33.00
	no, see instructions.					
	Provi der-Based Physi ci ans					
34.00	,	ırrangement wit	th provider-b	ased physicians?	Υ	34.00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		V /N	Doto	
				Y/N 1. 00	<u>Date</u> 2. 00	
	Home Office Costs			1.00	2.00	
36 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	e home office			37.00
55	If yes, see instructions.		000			
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different	t from that o	f N		38.00
	the provider? If yes, enter in column 2 the fiscal year en					
39. 00		er chain compo	onents? If ye	s, N		39. 00
	see instructions.					
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	i nstructi ons.					
		4	00		00	-
	Cost Poport Propagor Contact Information	1	. 00	2.	00	
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	MI CHAEL		ALESSANDRI NI		41.00
41.00	held by the cost report preparer in columns 1, 2, and 3,	INI CITALL		VEFOOUNDELINI		41.00
	respectively.					
42.00	Enter the employer/company name of the cost report	BLUE & CO., L	LC			42.00
	preparer.	]				
43.00	Enter the telephone number and email address of the cost	317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					
	-					

Health Financial Systems METHODIST HO	OSPITALS, INC	In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0002	From 01/01/2019   To 12/31/2019		pared:
			0/23/2020 6.0	3 alli
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DI RECTOR			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the 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, respectively.				

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0002

						То	12/31/2019	Date/Time   6/25/2020		
	·							1/P Days /		o alli
								0/P Vi si ts		
								Trips	<i>'</i>	
	Component	Worksheet A	No	. of Beds	Bed Days		CAH Hours	Title V		
	<u>'</u>	Line Number			Avai I abl e					
		1. 00		2. 00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		375	136, 87	'5	0. 00		0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
2 00	for the portion of LDP room available beds)		ŀ						- 1	2 00
2.00	HMO and other (see instructions)		ŀ						- 1	2.00
3.00	HMO I PF Subprovi der								- 1	3. 00 4. 00
4.00	HMO IRF Subprovider								0	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF								0	6.00
7. 00	Total Adults and Peds. (exclude observation		ŀ	375	124 07		0. 00		0	7. 00
7.00	beds) (see instructions)			3/3	136, 87	5	0.00		ال	7.00
8. 00	INTENSIVE CARE UNIT	31.00		27	9, 85		0.00		0	8. 00
8. 01	NEONATAL I CU	31.00		36			0.00		0	8. 01
9. 00	CORONARY CARE UNIT	31.01	ŀ	30	13, 14	.0	0.00		١	9. 00
10.00	BURN INTENSIVE CARE UNIT		ŀ						l	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								l	11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)								l	12.00
13. 00	NURSERY	43.00							o	13.00
14. 00	Total (see instructions)	10.00	ŀ	438	159, 87	'n	0.00		0	14.00
15. 00	CAH visits			.00	107,07		0.00		o	15. 00
16. 00	SUBPROVI DER - I PF	40.00		14	5, 11	0			o	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		39					o	17. 00
18.00	SUBPROVI DER								i	18. 00
19.00	SKILLED NURSING FACILITY								l	19.00
20.00	NURSING FACILITY								l	20.00
21.00	OTHER LONG TERM CARE								l	21.00
22.00	HOME HEALTH AGENCY	101.00							0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)								l	23.00
24.00	HOSPI CE									24.00
24. 10	HOSPICE (non-distinct part)	30.00							l	24. 10
25.00	CMHC - CMHC								l	25.00
26.00	RURAL HEALTH CLINIC									26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27.00	Total (sum of lines 14-26)			491						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		0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
00	outpatient days (see instructions)									
	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges				1				- 1	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | Date/Time | Prepared: | Date/Time | Prepared: | Part | Par Provider CCN: 15-0002

				T	o 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		I/P Davs	/ O/P Visits	/ Trips	Full Time F	Equi val ents	J dill
			,	p=			
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
	I	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	22, 149	2, 762	64, 992			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)	16, 082	21, 809				2.00
3. 00	HMO IPF Subprovider	10,002	21,009				3.00
4. 00	HMO IRF Subprovider		870				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0/0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	22, 149	2, 762	64, 992			7.00
7.00	beds) (see instructions)	22,	2,702	01,772			/
8.00	INTENSIVE CARE UNIT	4, 320	0	7, 574		•	8.00
8. 01	NEONATAL I CU	O	0	2, 213			8. 01
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		381	2, 632			13.00
14.00	Total (see instructions)	26, 469	3, 143	77, 411	0. 00	1, 989. 56	14.00
15.00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF	1, 363	0	3, 016			
17.00	SUBPROVI DER - I RF	4, 740	139	7, 786	0. 00	37. 05	
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	6, 763	4, 182	21, 756	0. 00	26. 69	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			304			24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	۷	0	0	0. 00 0. 00		1
28. 00	Total (sum of lines 14-26) Observation Bed Days		6, 279	19, 770		2, 068. 15	27. 00 28. 00
29. 00	Ambulance Trips	0	0, 219	19, 770			29.00
30.00	Employee discount days (see instruction)	٥		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	61	70			32.00
32. 00	Total ancillary labor & delivery room			0			32.00
JZ. 01	outpatient days (see instructions)			0			32.01
33. 00	LTCH non-covered days	О					33.00
	LTCH site neutral days and discharges	o					33. 01
					'	•	

Provider CCN: 15-0002 

				To	12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Full Time	_	Di sch	arges	0, 20, 2020 0.0	<u> </u>
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 441	450	12, 796	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, 082	419		2.00
3. 00	HMO IPF Subprovi der				0		3. 00
4. 00	HMO I RF Subprovi der				57		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8.00
8. 01	NEONATAL ICU						8. 01
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	0.00	0	4 441	450	10 70/	13.00
14.00	Total (see instructions)	0.00	0	4, 441	450	12, 796	
15. 00 16. 00	CAH visits	0.00	0		o	240	15. 00 16. 00
17. 00	SUBPROVIDER - IPF  SUBPROVIDER - IRF	0. 00 0. 00	0		10	461	17.00
18. 00	SUBPROVI DER	0.00	U	209	10	401	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE			•			21.00
22. 00	HOME HEALTH AGENCY	0.00		•			22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23.00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Thisti detroit)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32.00
52. 51	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	1		0			33. 00
	LTCH site neutral days and discharges			0			33. 01
		1		-1	ļ		

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	F	Period: From 01/01/2019 To 12/31/2019		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	DART III WASE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1. 00	Total salaries (see	200.00	149, 182, 530	-288, 714	148, 893, 816	4, 301, 742. 00	34. 61	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0		0.00	0. 00	2.00
	A			0				
3. 00	Non-physician anesthetist Part B		0	U		0.00	0. 00	
4. 00	Physician-Part A - Administrative		0	0	C	0.00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 3, 232, 882	0	1	0. 00 2 26, 349. 00	0. 00 122. 69	
	Physician-Part B			0				
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0. 00	6.00
7. 00	services Interns & residents (in an	21. 00	0	0		0.00	0. 00	7.00
	approved program)	21.00		0				
7. 01	Contracted interns and residents (in an approved		222, 850	0	222, 850	6, 240. 00	35. 71	7. 01
8. 00	programs) Home office and/or related		0	0	C	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	0	C	0. 00	0. 00	9. 00
10.00	Excluded area salaries (see instructions)		28, 451, 475	434, 924	28, 886, 399	574, 431. 00	50. 29	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		7, 130, 660	0	7, 130, 660	119, 879. 00	59. 48	11. 00
12.00	Contract Labor: Top Level		0	0	C	0. 00	0. 00	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		725, 651	0	725, 651	5, 183. 00	140. 01	13.00
14. 00	A - Administrative Home office and/or related		0	0	C	0.00	0. 00	14.00
	organization salaries and wage-related costs							
14. 01	Home office salaries		0	0				14.01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0			0. 00 0. 00	
	- Administrative		ŏ	O		0.00		
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16.00
16. 01	Home office Physicians Part A		0	0	C	0.00	0.00	16. 01
16. 02	- Teaching Home office contract		0	0	C	0. 00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		34, 151, 150	0	34, 151, 150	)		17. 00
18. 00	instructions) Wage-related costs (other)							18.00
19. 00	(see instructions) Excluded areas		5, 950, 880	0	5, 950, 880			19.00
20. 00	Non-physician anesthetist Part		0 0	0	3, 430, 880			20.00
21. 00	Non-physician anesthetist Part		0	0	C			21.00
22. 00	Physician Part A -		0	0	C			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00	Physician Part B		433, 803	0	433, 803	á l		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	C			24.00
25. 00	Interns & residents (in an approved program)		0	0	C	,		25.00
25. 50	Home office wage-related (core)		0	0	C			25. 50
25. 51	Related organization wage-related (core)		0	0	C			25. 51
25. 52	Home office: Physician Part A		0	0	C			25. 52
	- Administrative - wage-related (core)							
	· .	<u>'</u>	<u>'</u>					

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0002 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/25/2020 8:03 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1, 683, 288 -55, 100 1, 628, 188 3, 704. 00 439. 58 26.00 27.00 Administrative & General 5.00 21, 085, 016 -701, 322 20, 383, 694 645, 281. 00 31. 59 27.00 28. 00 1, 726, 611 1, 726, 611 8, 992. 00 192. 02 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 3, 830, 966 -9, 268 3, 821, 698 153, 661. 00 24.87 30.00 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 Housekeepi ng 9.00 4, 488, 456 -27, 123 4, 461, 333 285, 589. 00 15. 62 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 3, 342, 731 -1, 291, 672 2, 051, 059 102, 628. 00 19. 99 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 255, 262 1, 287, 486 1, 542, 748 76, 983. 00 20.04 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 3, 220, 339 3, 222, 427 65, 855. 00 48. 93 38.00 38.00 13.00 2.088 39.00 Central Services and Supply 14.00 619, 842 619, 842 33, 147. 00 18. 70 39.00 40.00 Pharmacy 15.00 0.00 0.00 40.00 Medical Records & Medical Records Library 41.00 41.00 16.00 1, 970, 757 -3, 882 1, 966, 875 82, 469. 00 23. 85 42.00 Social Service 17.00 407, 414 407, 414 13, 752. 00 29. 63 42. 00 43.00 Other General Service 18.00 0 0.00 0.00 43.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0002	Peri od: Worksheet S-3
		From 01/01/2019 Part III
		T 40 (04 (0040   D 1 (T)   D 1

						o 12/31/2019		
		Worksheet A	Amount	Reclassi fi cat	Adj usted	Pai d Hours	Average	3 alli
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		147, 453, 409	-288, 714	147, 164, 695	4, 278, 145. 00	34. 40	1.00
	instructions)							
2.00	Excluded area salaries (see		28, 451, 475	434, 924	28, 886, 399	574, 431. 00	50. 29	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		119, 001, 934	-723, 638	118, 278, 296	3, 703, 714. 00	31. 94	3.00
	minus line 2)							
4.00	Subtotal other wages & related		7, 856, 311	0	7, 856, 311	125, 062. 00	62. 82	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		34, 151, 150	0	34, 151, 150	0. 00	28. 87	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		161, 009, 395	-723, 638	160, 285, 757	3, 828, 776. 00	41. 86	6.00
7.00	Total overhead cost (see		42, 223, 268	-391, 379	41, 831, 889	1, 472, 061. 00	28. 42	7.00
	instructions)							

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0002	Period: From 01/01/2019	Worksheet S-3
			Date/Time Prepared:

	To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 101, 207	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5, 084, 027	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	16, 784, 840	
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	3, 049, 460	
10.00	Dental, Hearing and Vision Plan	887, 881	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	442, 170	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	288, 714	
14.00		0	
15.00		1, 290, 285	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	10, 233, 004	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	90, 806	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
	Tuition Reimbursement	283, 439	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	40, 535, 833	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

	5	METHODI OT HOOD!			6.5. 0110.6	
	Financial Systems	METHODIST HOSPI			u of Form CMS-2	
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 15-0002	Peri od:	Worksheet S-3	
				From 01/01/2019 To 12/31/2019		nared:
				10 12/31/2017	6/25/2020 8: 0	3 am
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				1. 00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi					
1.00	Total facility's contract labor and benefit	cost		7, 130, 660		
2.00	Hospi tal			7, 130, 660	40, 535, 833	2.00
3. 00	Subprovi der - IPF			0	0	3.00
4. 00	Subprovi der - IRF			0	0	4.00
5. 00	Subprovider - (Other)			0	0	5.00
6. 00	Swing Beds - SNF			0	0	6.00
7. 00	Swing Beds - NF			0	0	7.00
8. 00	Hospital-Based SNF					8.00
9. 00	Hospi tal-Based NF					9.00
10. 00	Hospi tal -Based OLTC					10.00
11. 00	Hospital-Based HHA			0	0	
12.00	Separately Certified ASC					12.00
13. 00	Hospi tal-Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
	Hospital-Based Health Clinic FQHC					15.00
	Hospi tal -Based-CMHC					16.00
	Renal Dialysis			0	0	
18. 00	Other			0	0	18.00

Heal th	Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
HOME H	BEALTH AGENCY STATISTICAL DATA			F	eriod: rom 01/01/2019		
-			Component	CCN: 15-7536   T	o 12/31/2019 Home Health	Date/Time Pre 6/25/2020 8:0 PPS	
					Agency I	PPS	
					1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	LIONE HEALTH ACENCY CTATLCTICAL DATA	1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1	1			1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	286. 00		0.00 oyees (Full Ti		2. 00
						q,	
			oer of hours in I work week	Staff	Contract	Total	
			_				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		0	1.00	2. 00	3. 00	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40.00	0. 00 0. 00		l .	3. 00 4. 00
5.00	Other Administrative Personnel			7. 38	0. 00	7. 38	5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			11. 11		•	6. 00 7. 00
8.00	Physical Therapy Service			4. 51	0. 00	4. 51	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 00 1. 21			9. 00 10. 00
11.00	Occupational Therapy Supervisor			0.00		1	11. 00 12. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 35 0. 00		1	•
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 04 0. 00		l	•
16.00	Home Health Aide			2. 14	0. 00	2. 14	16.00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			l
	HOME HEALTH AGENCY CBSA CODES			1			
19. 00	you provided services during the cost			'			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20. 00
	during this cost reporting period (line 20						
	contains the first code).	Full E	pi sodes				
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	3, 090					
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	578, 715 1, 624	1				22. 00 23. 00
24.00	Physical Therapy Visit Charges	332, 080	24, 675	5, 935	13, 285	375, 975	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	350 72, 420	1			l e	25. 00 26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	72 15, 896					27. 00 28. 00
29. 00	Medical Social Service Visits	15, 896	3	0		8	29.00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	1, 495 577	B .	1	0 34	,	30. 00 31. 00
32.00	Home Health Aide Visit Charges	48, 304	9, 304	84	2, 856	60, 548	32.00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5, 718	717	116	212	6, 763	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	1, 048, 910	126, 444	1			34.00 35.00
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	309		42	16		36.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	97, 322	17 15, 969		1 827		37. 00 38. 00

Heal th	Financial Systems METHODIST HOSPITA	LS, INC		In Lie	u of Form CMS-2	2552-1 <u>0</u>	
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	CN: 15-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-1 Date/Time Pre 6/25/2020 8:0	pared:	
					1. 00		
1 00	Uncompensated and indigent care cost computation			0)	0.000040	1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	vraea by ri	ne 202 coi u	mn 8)	0. 223842	1.00	
2.00	Net revenue from Medicaid				72, 236, 982	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?	<b>.</b>		: -10	Y	3.00	
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments fi			cai d?	Y	4. 00 5. 00	
6. 00	Medi cai d charges	on mourea	u		340, 117, 285		
7. 00	Medicaid cost (line 1 times line 6)				76, 132, 533		
8. 00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 3,895,551 8. < zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions for	or each lir	ne)				
9. 00	Net revenue from stand-alone CHIP				0		
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0		
	enter zero)						
13. 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				0	13.00	
14. 00	Charges for patients covered under state or local indigent care				0		
	10)						
15.00	State or local indigent care program cost (line 1 times line 1)		n nrogram (I	ino 15 minuo lino	0		
16. 00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 10 11; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00					0		
18. 00 19. 00	Government grants, appropriations or transfers for support of I Total unreimbursed cost for Medicaid, CHIP and state and Iocal 8, 12 and 16)	ms (sum of lines	0 3, 895, 551				
	1		Uni nsured	Insured	Total (col. 1		
			patients 1.00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20. 00	Charity care charges and uninsured discounts for the entire factories (see instructions)	cility	32, 463, 4	32 5, 105, 791	37, 569, 223	20.00	
21. 00	Cost of patients approved for charity care and uninsured disconinstructions)	unts (see	7, 266, 6	5, 105, 791	12, 372, 471	21.00	
22. 00	Payments received from patients for amounts previously written charity care	off as		0 0	0	22.00	
23. 00	Cost of charity care (line 21 minus line 22)		7, 266, 6	80 5, 105, 791	12, 372, 471	23.00	
					1. 00		
24. 00	Does the amount on line 20 column 2, include charges for patien		yond a Lengt	n of stay limit	N	24.00	
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the charges for patients are considered.		t care progr	am's length of	0	25. 00	
26. 00	stay limit Total bad debt expense for the entire hospital complex (see in:	structions	)		25, 162, 002	26. 00	
27. 00	Medicare reimbursable bad debts for the entire hospital complex	x (see insi	tructions)		1, 106, 768	27. 00	
27. 01	Medicare allowable bad debts for the entire hospital complex (	see instrud	ctions)		1, 702, 719		
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	nense (see	instruction	5)	23, 459, 283 5, 847, 124	1	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(300		= /	18, 219, 595		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			22, 115, 146	31.00	

Cost Center Description		FINANCIAI SYSTEMS	METHODIST HOSP		N 45 0000 B		U OT FORM CMS-2	2552-10
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC			Worksheet A	
Cost Center Description								
Company   Comp						1 1		3 am
		Cost Center Description	Sal ari es	0ther				
Column   C					+ COI. 2)			
						A-0)		
DEBRIEL SERVICE COST CENTERS			1 00	2 00	3 00	4 00		
1.00   100/09   LAP FELL COSTS -BLIC & FIXT   1, 661, 268   77, 833, 79   2, 516, 816   223, 737   10, 802, 79   5. 01   10, 803, 79   7, 833, 79		GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
5.01 OBSSEIDNIA PROCESSING  OBSSEIDNIA PROCES	1.00			0	0	21, 043, 102	21, 043, 102	1.00
0.00500   PURCHASING RECEIVING AND STORES   \$77,055   \$0.0073   31,0074,0070   \$14,0091   \$2,091   \$44,188   \$2,917,7   \$6,077   \$2,374,098   \$5.00   \$0.00500   \$2.00510   \$1.00500   \$2	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 683, 288	27, 833, 528	29, 516, 816	223, 787	29, 740, 603	4.00
5.03   0.0076   ASMITTING   1,935, 299   446, 188   2,381,477   -0,779   2,374,698   5.05   0.0080   O.0094	5. 01	00550 DATA PROCESSING	3, 998, 413	9, 039, 923	13, 038, 336	-2, 235, 427	10, 802, 909	5. 01
5.04   OBSIND CASSILERIN MYACCIOUNTS FIRTCH VAILE   2,479, and 4								
10.000   DISPAPADING   11.742,551   22.419,203   33.661,754   12.919,435   20.82,319   5.00   20.000   DISPAPADING   12.914,032   20.82,319   5.00   20.000   DISPAPADING   18.000   20.0000   20.000   20.000   20.000   20.0000   20.0000   20.000   20.0000   20.0000   20.0000   20.								
5.00 00992 PATIENT TRANSPORTATION 552,024 9, 104 221,188 4, -21,410 99,778 5.00 00000 DEPARTION OF PRIATOT 38,380,966 9,113,116 12,044,022 47,16,581 12,690,260 10,00000 DEPARTION OF PRIATOT 4,480,40 1,453,779 1,453,779 10,00000 DEPARTION OF PRIATOT 4,480,40 1,453,779 10,00000 DEPARTION OF PRIATOT 4,480,40 1,453,779 1,453,779 10,00000 DEPARTION OF PRIATOT 4,480,40 1,453,779 1,453,779 10,00000 DEPARTINO SERVICES 5,00000 1,450,40 1,45								1
0.00700   DOTODIO   DEPARTION OF PLANT   3,830,960   9,113,110   12,944,082   7,745,538   17,699,620   7,09   0.00   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000								
0.00 00800 LAURDRY & LINEN SERVICE  0.00 00000 (DISTEREP INC. 4, 48B, 456 1, 290 (BB) 97, 787, 545 2-232, 982 5, 534, 533 2-210, 00 10000 DISTEREP INC. 3, 342, 731 2, 730, 238 6, 072, 690 2-2, 519, 147 3, 553, 322 10 11, 00 10100 CIRTERIA IN STRATION 3, 553, 262 11, 00 11,		1 1						1
0.00 (0.0900) (0.0910) (0.0916								
10.00   01000   DETARY   3.342,731   2.730,238   6.072,90   2.519,147   3.553,827   10.00   10.00   10.00   CEFEERIA   2.223,337   5.55,262   3.837   2.837   2.837   2.328,009   2.519,147   3.553,827   10.00   10.00   PIRAMACKY   0   13.00   PIRAMACKY   0   10.00   PIRAMACKY   0   0   0   0   0   0   0   0   0			-					
11.00   01100   CAFETERIA   25.5, 26.2   32, 837   288, 099   2, 441, 243   2, 729, 342   11.00   13.00   01300   MIRSTRATION   3, 220, 339   6.6, 870   3, 787, 209   5, 787, 209   1, 787, 200   1, 200		1 1						1
14.00 0 1400 CENTRAL SERVICES & SUPPLY 619, 842 1, 331, 179 1, 051, 021 -407, 511 1, 1,543, 510 14.00 14.00 0 1600 MEDICAL RECORDS & LIBRARY 1,970, 757 854, 546 2, 875, 303 -10, 412 2, 814, 891 16.00 14.00 0 10 10 17, 71 17, 7								1
15.00   01500   PHARMACY   19.00   13,097,152   13,097,152   -7,983,411   5,173,741   15,00   1700   01700   50C1AL SERVICE   0   0   0   0   0   0   0   0   0	13.00	01300 NURSING ADMINISTRATION	3, 220, 339	566, 870	3, 787, 209	-53, 064	3, 734, 145	13.00
16.00 0 14600 [MFDI CAIL RECORDS & LI BRARY   1,970,757   854,546   2,825,303   -10,141   2,814,99   16.00   17.01   17.01   17.00   1	14.00		619, 842	1, 331, 179	1, 951, 021	-407, 511	1, 543, 510	
17.00   01700   SOCIAL SERVICE   0   0   0   407,414   407,414   17.00   17.								
17.01   01701   STAFF EDUCATION   0   0   0   0   0   17.70   17.02								
17.00   01702   MEDICAL EDUCATION   0   44,765   44,765   1.48   44,617   17.02   17			0	0	0			
21.00			0	0	0			1
22.00   02200   RAY SERVICES-OTHER PROM COSTS APPRVD   0			0					
23.00			٥	0				1
INPATI ENT ROUTINE SERVICE COST CENTERS   31,703,111   12,212,997   43,916,008   -746,525   43,169,483   30.00   30.00   ADURTS & PEDIDI ATRICS   5,977,237   2,312,433   8,289,880   -746,525   43,169,483   30.00   31.00   3101   NORMATAL ICU   1,560,179   1,187,072   2,717,475   -34,797   2,712,403   31.01   31.01   03101   ROMATAL ICU   1,560,179   1,187,072   2,717,475   -34,797   2,712,403   31.01   31.01   03101   ROMATAL ICU   1,560,179   1,187,072   2,712,40,67   -344,477   2,712,400   31.01   03101   03400   SUBPROVI DER - I PF   1,214,815   109,242   1,324,607   -16,407   1,307,560   41.00			٦	70 108	-	,		
30.00   03000   ADULTS & PEDIATRICS   31, 703, 111   12, 212, 897   43, 916, 008   -746, 525   42, 169, 483   30.00   31.01   01   NTENSINE CARE UNIT   5, 977, 727   2, 121, 243   2, 898   80   -719, 035   7, 570, 845   31.01   03101   NEONATAL I LOU   1, 560, 179   1, 187, 072   2, 747, 251   -34, 791   2, 712, 460   31.01   01.00   04.00   04000 SUBPROVIDER - I PF   1, 214, 815   109, 424   1, 24, 057   -14, 971   1, 307, 560   40.01   04.10   04.10   05 SUBPROVIDER - I PF   2, 666, 443   404, 363   3, 070, 806   -55, 300   3, 015, 506   41.00   04.00   04000 SUBPROVIDER   1, 236, 156   358, 778   1, 594, 941   -102, 808   1, 492, 126   43.00   04300   04300   04300   04300   04300   04300   04300   09FRATING ROOM   3, 906, 802   16, 401, 878   20, 307, 960   -13, 509, 602   6, 798, 388   50.00   05000   0FRATING ROOM   1, 041, 229   127, 170   1, 168, 399   -1, 42, 22   1, 155, 977   51.00   05100   RECOVERY ROOM   1, 041, 229   127, 170   1, 168, 399   -1, 42, 22   1, 155, 977   51.00   05100   RECOVERY ROOM   2, 951, 108   508, 966   3, 460, 074   -195, 476   3, 264, 598   50.00   05200   DELIVERY ROOM   2, 951, 108   508, 966   3, 460, 074   -195, 476   3, 264, 598   50.00   05200   DELIVERY ROOM   2, 384, 403   2, 521, 071   4, 905, 474   -904, 713   4, 000, 761   54.00   05400   ARSTHICSTORY   2, 384, 403   2, 521, 071   4, 905, 474   -904, 713   4, 000, 761   55.00   05500 RADIOLOGY - ULTRASOUND   1, 213, 46   1, 108, 976   2, 232, 22   519, 890   1, 712, 532   54.00   05500 RADIOLOGY - ULTRASOUND   1, 213, 46   1, 108, 976   2, 232, 22   519, 890   1, 712, 532   54.00   05500 RADIOLOGY - HERAPEUTIC   467, 047   2, 321, 213   2, 788, 260   -755, 291   2, 032, 969   55.00   05500 RADIOLOGY - HERAPEUTIC   467, 047   2, 321, 213   2, 788, 260   -755, 291   2, 032, 969   55.00   05500 RADIOLOGY - HERAPEUTIC   467, 047   71, 44, 905, 243, 243, 243, 243, 243, 243, 243, 243	23.00		471,075	77, 100	330, 201	201, 113	011, 770	25.00
31.00 03100 INTENSIVE CARE UNIT 5, 977, 237 2, 312, 643 8, 289, 880 -719, 035 7, 570, 845 31.00 03101 INTENSIVE CARE UNIT 1.560, 179 1, 187, 072 2, 247, 251 3-34, 791 2, 712, 460 31.00 04000 SUBPROVI DER - I PF 1.214, 815 109, 242 1, 1324, 057 -16, 497 1, 307, 560 40.00 40.00 04000 SUBPROVI DER - I PF 1.214, 815 109, 242 1, 1324, 057 -16, 497 1, 307, 560 40.00 4300 NURSERY 1.236, 156 358, 778 1, 1594, 934 -102, 808 1, 492, 126 43.00 4300 NURSERY 1.236, 156 358, 778 1, 1594, 934 -102, 808 1, 492, 126 43.00 4300 NURSERY 1.248 YESPROVE COST CENTERS 1.236, 156 358, 778 1, 1594, 934 -102, 808 1, 492, 126 43.00 4300 NURSERY 1.248 YESPROVE COST CENTERS 1.256 4.00 6500 DELOVERY ROOM 1.041, 229 127, 170 1, 168, 399 -12, 422 1, 155, 977 15.00 510 0500 DELIVERY ROOM 2.2951, 108 508, 966 3, 460, 074 -195, 476 3, 246, 598 52.00 05200 DELIVERY ROOM & LABOR ROOM 2.951, 108 508, 966 3, 460, 074 -195, 476 3, 246, 598 52.00 05200 ANESTHESIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00		31, 703, 111	12, 212, 897	43, 916, 008	-746, 525	43, 169, 483	30.00
31.01   03101   NEONATAL   LOU								
41. 00   04100   SUBPROVI DER - I RF   2,666, 443   404, 363   3,070, 806   -55,300   3,015,506   41. 00   A300   A300   MURSERY   1,266,156   338, 778   1,594, 934   -102,808   1,492,126   50. 00   S000   DERATI IN ROOM   3,906, 082   16,401,878   20,307,900   -13,509,602   -13,	31. 01	03101 NEONATAL I CU	1, 560, 179		2, 747, 251	-34, 791	2, 712, 460	31.01
A3 OD   Q4300   Q4500   Q450	40.00	04000 SUBPROVI DER - I PF	1, 214, 815	109, 242	1, 324, 057	-16, 497	1, 307, 560	40.00
ANCIL LARY SERVICE COST CENTERS   50.00   CROON   ROOM   S. 906, 082   16, 401, 878   20, 307, 960   -13, 509, 602   6, 798, 358   50.00   CROON   PROPATING ROOM   1, 155, 257   1, 786, 400   2, 941, 657   -349, 421   2, 592, 236   50.01   51.00   DSIOD   RECOVERY ROOM   1, 041, 229   127, 170   1, 168, 399   -12, 422   1, 155, 775   51.00   53.00   05300   OSCO)   RELEVENT ROOM   2, 951, 108   508, 966   3, 460, 074   -195, 476   3, 264, 598   52.00   53.00   05300   ARSTHESIS ILOGY   0   0   0   0   0   0   0   0   0	41.00	04100 SUBPROVI DER - I RF	2, 666, 443	404, 363	3, 070, 806	-55, 300	3, 015, 506	41.00
50. 00	43.00		1, 236, 156	358, 778	1, 594, 934	-102, 808	1, 492, 126	43.00
50.00	F0 00		2 22 / 222	47 404 070	00 007 010	10.500 (00)	/ 700 050	
1. 0   05100   DECOVERY ROOM   ALBOR ROOM   1. 041, 229   127, 170   1, 168, 399   -12, 422   1, 155, 977   51, 00   52, 00   DELIVERY ROOM   ALBOR ROOM   2, 951, 108   508, 966   0   0   0   0   0   0   0   0   0		1 1						
52.00   05200   DELIVERY ROOM & LABOR ROOM   2, 951, 108   508, 966   3, 460, 074   -195, 476   3, 264, 598   52.00   053.00   055.00   054.00   054.00   055.00   055.00   055.00   RADIOLOGY - HERAPEUTIC   467, 047   2, 321, 213   2, 788, 260   -755, 291   2, 032, 699   55.00   055.00   RADIOLOGY - HERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   55.00   055.00   RADIOLOGY - HERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   55.00   055.00   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 320   2, 145, 057   -240, 725   1, 044, 332   56.00   056.00   05600   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 332   56.00   05600   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 332   56.00   05600   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 932   56.00   05600   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 932   56.00   05600   RADIOLOGY - HERAPEUTIC   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 932   56.00   05600   RADIOLOGY   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 094, 932   56.00   05600   RADIOLOGY   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 099, 193   58.00   05600   RADIOLOGY   406, 713   1, 346, 468   1, 753, 181   -743, 988   1, 099, 193   58.00   05600   RADIOLOGY   406, 713   1, 446, 468   1, 753, 181   -743, 988   1, 499, 194   1, 493, 194   1,		1 1						
53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   53.05								
54. 01   05400   RADI OLOGY-DI ARMOSTIC   2, 384, 403   2, 521, 071   4, 905, 474   -904, 713   4, 000, 761   54. 05   054. 01   05401   RADI OLOGY - ULTRASOUND   1, 213, 446   1, 018, 976   2, 232, 422   -519, 890   1, 712, 532   54. 01   05501   INFUSI ON CENTER   8, 099   7, 134   15, 233   -5, 154   10, 079   55. 00   05500   RADI OLOGY-THERAPEUTIC   467, 047   2, 321, 213   2, 788, 260   -755, 291   2, 032, 969   55. 00   05000   RADI OLOGY-THERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   55. 00   05000   RADI OLOGY-THERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   55. 00   05000   RADI OLOGY-THERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   35. 00   05000   RADI OLOGY-THERAPEUTIC   8, 099   7, 134   15, 233   -5, 154   10, 079   35. 00   05000   RADI OLOGY-THERAPEUTIC   406, 3711   1, 447, 805   2, 511, 516   -541, 044   1, 970, 472   57. 00   05000   CARDIAC CATHETER IZATI ON   2, 119, 463   5, 608, 287   7, 727, 750   -4, 340, 067   3, 387, 683   59. 00   00000   0   0   0   0   0   0   0			2, 931, 100	300, 900	3, 460, 074			
54.01   CADIT   CADI			2 384 403	2 521 071	4 905 474			1
55. 00   05500   RADI OLOGY-THERAPEUTIC								1
55.01   05501   INFUSI ON CENTER								
57.00   05700   CT SCAN   1,063,711   1,447,805   2,511,516   -541,044   1,970,472   57.05     58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   406,713   1,346,468   1,753,181   -743,988   1,009,193   58.00     59.00   05900   CARDIAC CATHETERIZATION   2,119,463   5,608,287   7,727,750   -4,340,067   3,387,683   59.00     60.01   06001   BLODD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 01	05501 INFUSION CENTER	8, 099	7, 134	15, 233	-5, 154	10, 079	
58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   406, 773   1,346,468   1,753,181   -743,988   1,009,193   58.00   59.00   05900   CARDI AC CATHETERI ZATI ON   2,119,463   5,608,287   7,727,750   -4,340,667   3,387,683   59.00   60.01   06000   LABORATORY   3,550,720   6,141,160   9,691,880   -75,304   9,616,576   60.00   60.01   06000   BLOOD LABORATORY   0   0   0   0   0   0   0   61.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   0   0   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1,145,826   343,188   1,489,014   -9,817   1,479,197   62.00   63.00   06200   WHOLE BLOOD & PROCESSI NG & TRANS.   0   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   65.00   06500   RESPI RATORY THERAPY   2,445,723   1,102,452   3,548,175   -331,816   3,216,359   65.00   66.00   06600   PHYSI CAL THERAPY   1,379,574   159,187   1,538,761   -2,152   1,536,609   66.00   67.00   06700   OCCUPATI ONAL THERAPY   1,183,313   69,968   1,280,281   -442   1,279,839   67.00   69.00   06900   SPEECH PATHOLOGY   719,542   287,410   1,006,952   -189,037   817,915   69.00   69.01   06901   CARDI AC REHAB   411,500   387,502   799,002   -214,827   584,175   69.01   69.01   06901   CARDI AC REHAB   411,500   387,502   799,002   -214,827   584,175   69.01   69.01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   11,776,424   11,776,424   17,700   71.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   10,045,657   10,045,657   72.00   71.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   10,045,657   10,045,657   72.00   71.00   07000   DEURS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0			513, 737	1, 631, 320	2, 145, 057			
59.00   05900   CARDIAC CATHETERI ZATION   2,119,463   5,608,287   7,727,750   -4,340,067   3,387,683   59.00		1 1						
60. 00   0.000   0.000   0.000   0.000   0.000   0.000   0.00   0.000								
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0		1 1						1
61.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   61.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1,145,826   343,188   1,489,014   -9,817   1,479,197   62.00   63.00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPY   2,445,723   1,102,452   3,548,175   -331,816   3,216,359   65.00   65.00   06500   RESPI RATORY THERAPY   2,445,723   1,102,452   3,548,175   -331,816   3,216,359   65.00   66.00   06600   PHYSI CAL THERAPY   1,379,574   159,187   1,538,761   -2,152   1,536,609   66.00   67.00   06600   PHYSI CAL THERAPY   1,183,313   96,968   1,280,281   -442   1,279,839   67.00   68.00   06800   SPECH PATHOLOGY   466,863   52,054   518,917   -2,005   516,912   68.00   69.00   06900   ELECTROCARDI OLOGY   719,542   287,410   1,006,952   -189,037   817,915   69.00   69.01   06901   CARDI AC REHAB   411,500   387,502   799,002   -214,827   584,175   69.01   69.01   06901   CARDI AC REHAB   411,500   387,502   799,002   -214,827   584,175   69.01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   11,776,424   11,776,424   11,776,424   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   10,045,657   10,045,657   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   405,415   1,509,719   1,915,134   13,956,320   15,871,454   73.00   74.00   07400   RENAL DI ALYSI S   164   2,076,105   2,076,269   -1,634   2,074,635   74.00   0000   09100   EMERGENCY   2,123,190   394,239   2,517,429   -17,524   2,499,905   10.00   09100   EMERGENCY   2,123,190   394,239   2,517,429   -17,524   2,499,905   118.00    10.00   SUBTOTALS (SUM OF LINES 1 through 117)   127,206,596   178,840,731   306,047,327   3,057,493   309,104,820   118.00   10.00   SUBTOTALS (SUM OF LINES 1 through 117)   127,206,596   178,840,731   306,047,327   3,057,493   309,104,820   118.00   10.00   SUBTOTALS (SUM OF LINES 1 through 117)   127,206,596   178,840,731   306,047,327   3,057,493   309,104,820   118.00   10.00   SUBTOTALS				6, 141, 160				
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1, 145, 826   343, 188   1, 489, 014   -9, 817   1, 479, 197   62.00   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPY   2, 445, 723   1, 102, 452   3, 548, 175   -331, 816   3, 216, 359   65.00   65.00   06500   RESPIRATORY THERAPY   1, 379, 574   159, 187   1, 538, 761   -2, 152   1, 536, 609   66.00   66.00   06600   PHYSI CAL THERAPY   1, 183, 313   96, 968   1, 280, 281   -442   1, 279, 839   67.00   67.00   06700   OCCUPATI ONAL THERAPY   1, 183, 313   96, 968   1, 280, 281   -442   1, 279, 839   67.00   69.01   06900   ELECTROCARDI OLOGY   719, 542   287, 410   1, 006, 952   -189, 037   817, 915   69.00   69.01   06901   CARDI AC REHAB   411, 500   387, 502   799, 002   -214, 827   584, 175   59.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   11, 776, 424   11, 776, 424   71.00   72.00   07200   TMPL. DEV. CHARGED TO PATI ENTS   0   0   0   10, 045, 657   10, 045, 657   73.00   07300   RUNGS CHARGED TO PATI ENTS   0   0   0   10, 045, 657   10, 045, 657   74.00   07400   RENAL DI ALYSI S   164   2, 076, 105   2, 076, 269   -1, 634   2, 074, 635   74.00   07400   RENAL DI ALYSI S   164   2, 076, 105   2, 076, 269   -1, 634   2, 074, 635   74.00   07400   RENAL DI ALYSI S   164   2, 076, 105   2, 076, 269   -1, 634   2, 074, 635   75.00   07400   OSERVATI ON BEDS (NON-DI STI NCT PART)   1, 434, 374   4, 364, 333   11, 798, 707   -1, 096, 912   10, 701, 795   75.00   OSERVATI ON BEDS (NON-DI STI NCT PART)   1, 27, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   18.00   75.00   SUBITOTALS (SUM OF LINES 1 through 117)   127, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   18.00   75.00   SUBITOTALS (SUM OF LINES 1 through 117)   127, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   18.00   75.00   100, 000   000   000   000   000   000   000   000   000   000   000   000   000   000   000			U	0	0	0		1
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   63. 00   64. 00   06400   INTRAVENOUS THERAPPY   2, 445, 723   1, 102, 452   3, 548, 175   -331, 816   3, 216, 359   65. 00   65. 00   06500   RESPI RATORY THERAPY   1, 379, 574   159, 187   1,538, 761   -2, 152   1, 536, 609   66. 00   66. 00   06600   PHYSI CAL THERAPY   1, 379, 574   159, 187   1,538, 761   -2, 152   1, 536, 609   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   1, 183, 313   96, 968   1, 280, 281   -442   1, 279, 839   67. 00   68. 00   06800   SPECH PATHOLOGY   466, 863   52, 054   518, 917   -2, 005   516, 912   69. 01   06901   CARDI AC REHAB   411, 500   387, 502   799, 002   -214, 827   584, 175   69. 01   06901   CARDI AC REHAB   411, 500   387, 502   799, 002   -214, 827   584, 175   71. 00   07000   ELECTROENCEPHALOGRAPHY   880, 816   9, 582, 511   10, 463, 327   -9, 317, 758   1, 145, 569   71. 00   07000   ELECTROENCEPHALOGRAPHY   880, 816   9, 582, 511   10, 463, 327   -9, 317, 758   1, 145, 569   71. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0 0 0 0 10, 045, 657   10, 045, 657   72. 00   07200   DRUGS CHARGED TO PATI ENTS   0 0 0 0 10, 045, 657   10, 045, 657   73. 00   07300   DRUGS CHARGED TO PATI ENTS   405, 415   1, 509, 719   1, 915, 134   13, 956, 320   15, 871, 454   73. 00   74. 00   07400   RENAL DI ALYSI S   164   2, 076, 105   2, 076, 269   -1, 634   2, 074, 635   74. 00   09000   CLI NI C   2, 503, 590   2, 303, 267   4, 806, 857   -290, 962   4, 515, 895   74. 00   09000   CLI NI C   2, 503, 590   2, 303, 267   4, 806, 857   -290, 962   4, 515, 895   75. 00   09000   CLI NI C   2, 503, 590   2, 303, 267   4, 806, 857   -290, 962   4, 515, 895   75. 00   09000   CLI NI C   2, 503, 590   2, 303, 267   4, 806, 857   -290, 962   4, 515, 895   75. 00   09000   CLI NIC   COST CENTERS   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   100000   100000   1000000   100000000		1 1	1 145 826	343 188	1 489 014	_9 817	-	
64. 00 06400   INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 65.00 RESPIRATORY THERAPY 2,445,723 1,102,452 3,548,175 -331,816 3,216,359 65. 00 66. 00 66600 PHYSI CAL THERAPY 1,379,574 159,187 1,538,761 -2,152 1,536,609 66. 00 667. 00 06700   OCCUPATI ONAL THERAPY 1,183,313 96,968 1,280,281 -422 1,279,839 67. 00 6800   SPEECH PATHOLOGY 466,863 52,054 518,917 -2,005 516,912 68. 00 69. 00 6900   ELECTROCARDI OLOGY 719,542 287,410 1,006,952 -189,037 817,915 69. 00 69. 01 06901   CARDI AC REHAB 411,500 387,502 799,002 -214,827 584,175 69. 01 06901   CARDI AC REHAB 411,500 387,502 799,002 -214,827 584,175 69. 01 70,200   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 11,776,424 11,776,424 11,776,424 17,706,425 172. 00 07200   MPLD. DEV. CHARGED TO PATI ENTS 0 0 0 11,776,424 11			1, 173, 020	3+3, 100 N	1, <del>1</del> 07, 014	9, 017 N		1
65. 00   06500   RESPIRATORY THERAPY   2, 445, 723   1, 102, 452   3, 548, 175   -331, 816   3, 216, 359   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 379, 574   159, 187   1, 538, 761   -2, 152   1, 536, 609   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   1, 183, 313   96, 968   1, 280, 281   -442   1, 279, 839   67. 00   68. 00   06800   SPEECH PATHOLOGY   466, 863   52, 054   518, 917   -2, 005   516, 912   68. 00   69.			o	o o	n			64.00
66. 00 06600 PHYSI CAL THERAPY 1, 379, 574 159, 187 1, 538, 761 -2, 152 1, 536, 609 66. 00 6700 0CCUPATI ONAL THERAPY 1, 183, 313 96, 968 1, 280, 281 -442 1, 279, 839 67. 00 68. 00 06800 SPEECH PATHOLOGY 466, 863 52, 054 518, 917 -2, 005 516, 912 68. 00 6900 ELECTROCARDI OLOGY 719, 542 287, 410 1, 006, 952 -189, 037 817, 915 69. 01 06901 CARDI AC REHAB 411, 500 387, 502 799, 002 -214, 827 584, 175 69. 01 07000 ELECTROENCEPHALOGRAPHY 880, 816 9, 582, 511 10, 463, 327 -9, 317, 758 1, 145, 569 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 11, 776, 424 11, 776, 424 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 10, 045, 657 10, 045, 657 72. 00 07300 DRUGS CHARGED TO PATI ENTS 405, 415 1, 509, 719 1, 915, 134 13, 965, 320 15, 871, 454 73. 00 07400 RENAL DI ALYSI S 164 2, 076, 105 2, 076, 269 -1, 634 2, 074, 635 74. 00 07400 RENAL DI ALYSI S 164 2, 076, 105 2, 076, 269 -1, 634 2, 074, 635 74. 00 09100 EMERGENCY 7, 434, 374 4, 364, 333 11, 798, 707 -1, 096, 912 10, 701, 795 91. 00 09100 EMERGENCY 7, 434, 374 4, 364, 333 11, 798, 707 -1, 096, 912 10, 701, 795 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS  101. 00 SUBTOTALS (SUM OF LINES 1 through 117) 127, 206, 596 178, 840, 731 306, 047, 327 3, 057, 493 309, 104, 820 118. 00 NONREI MBURSABLE COST CENTERS			2, 445, 723	1, 102, 452	3, 548, 175	-331, 816	3, 216, 359	1
67. 00		1 1						1
68. 00   06800   SPEECH PATHOLOGY   466, 863   52, 054   518, 917   -2, 005   516, 912   68. 00   69. 01   06900   ELECTROCARDI OLOGY   719, 542   287, 410   1, 006, 952   -189, 037   817, 915   69. 00   69. 01   06901   CARDI AC REHAB   411, 500   387, 502   799, 002   -214, 827   584, 175   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   880, 816   9, 582, 511   10, 463, 327   -9, 317, 758   1, 145, 569   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   11, 776, 424   11, 776, 424   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   10, 045, 657   10, 045, 657   73. 00   07300   DRUGS CHARGED TO PATIENTS   405, 415   1, 509, 719   1, 915, 134   13, 956, 320   15, 871, 454   73. 00   74. 00   07400   RENAL DI ALYSIS   164   2, 076, 105   2, 076, 269   -1, 634   2, 074, 635   74. 00   09000   CLI NI C   2, 503, 590   2, 303, 267   4, 806, 857   -290, 962   4, 515, 895   79. 00   09000   DEMERGENCY   7, 434, 374   4, 364, 333   11, 798, 707   -1, 096, 912   10, 701, 795   79. 00   09200   DESERVATION BEDS (NON-DISTINCT PART)   07HER REIMBURSABLE COST CENTERS  101. 00   SUBTOTALS (SUM OF LINES 1 through 117)   127, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   127, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   118. 00   NONREIMBURSABLE COST CENTERS	67. 00							
69. 01 06901 CARDI AC REHAB 411, 500 387, 502 799, 002 -214, 827 584, 175 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 880, 816 9, 582, 511 10, 463, 327 -9, 317, 758 1, 145, 569 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 11, 776, 424 11, 776, 424 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 10, 045, 657 10, 045, 657 72. 00 07300 DRUGS CHARGED TO PATI ENTS 405, 415 1, 509, 719 1, 915, 134 13, 956, 320 15, 871, 454 73. 00 07400 RENAL DI ALYSI S 164 2, 076, 105 2, 076, 269 -1, 634 2, 074, 635 74. 00 000 0000 CLI NI C 2, 503, 590 2, 303, 267 4, 806, 857 -290, 962 4, 515, 895 90. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0000 DESERVATI ON BEDS (NON-DI STI NCT PART) 0000 DESERVATI ON BEDS (NON-DI STI NCT PART) 0000 DESERVATI ON BEDS (SUM OF LI NES 1 through 117) 127, 206, 596 178, 840, 731 306, 047, 327 3, 057, 493 309, 104, 820 118. 00 NONREI MBURSABLE COST CENTERS	68. 00						·	1
70. 00		1 1					· ·	1
71. 00								1
72. 00								1
73. 00			-					
74. 00			-	-1	-			
90. 00   OUTPATI ENT SERVI CE COST CENTERS   90. 00   OUTPATI ENT SERVI CE CENTERS   90. 00   OUTPATI ENT SERVI CE CENTERS   90. 00   OUTPATI ENT SERVI CE C								
90. 00	, 4. 00		104	2,070,100	2,010,209	- 1, 034	2,014,033	, 4. 00
91. 00	90.00		2, 503, 590	2, 303, 267	4. 806. 857	-290, 962	4, 515, 895	90.00
92. 00								1
OTHER REIMBURSABLE COST CENTERS  101. 00				,			,	92.00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   127, 206, 596   178, 840, 731   306, 047, 327   3, 057, 493   309, 104, 820   118. 00   NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTER								
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 127, 206, 596 178, 840, 731 306, 047, 327 3, 057, 493 309, 104, 820 118. 00 NONREI MBURSABLE COST CENTERS	101.00		2, 123, 190	394, 239	2, 517, 429	-17, 524	2, 499, 905	101.00
NONREI MBURSABLE COST CENTERS								1
	118.00		127, 206, 596	178, 840, 731	306, 047, 327	3, 057, 493	309, 104, 820	1118. 00
190.00 19000 GIF1, FLOWER, COFFEE SHOP & CANTEEN   0  1,164  1,164  -1,153  11 190.00	100.00			4 47.1	4 4	4 450		100 00
	190.00	JIYUUU GIFI, FLOWER, COFFEE SHOP & CANTEEN	0	1, 164	1, 164	-1, 153	11	1190.00

Health Financial Systems	METHODIST HOSP	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2019 Fo 12/31/2019		pared: 3 am
Cost Center Description	Sal ari es	0ther	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	
191. 00 19100 RESEARCH	0	0		0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	21, 809, 167	13, 904, 172	35, 713, 33 <sup>9</sup>	-1, 062, 187	34, 651, 152	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	2, 636, 108	2, 636, 10	-1, 994, 153	641, 955	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	166, 767	47, 569	214, 33	6	214, 336	192. 02
193. 00 19300 NONPALD WORKERS	o	0		0	0	193. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	149, 182, 530	195, 429, 744	344, 612, 27	1 0	344, 612, 274	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

Peri od: Worksheet A

90.00

91.00

92.00

101.00

118.00

190.00

191 00

From 01/01/2019 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocati on 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT -1, 844, 563 19, 198, 539 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 854, 798 31, 595, 401 4.00 00550 DATA PROCESSING -199, 492 10, 603, 417 5 01 5 01 5.02 00560 PURCHASING RECEIVING AND STORES 3, 818, 330 5.02 00570 ADMITTING 2, 374, 698 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE -71, 234 6, 720, 823 5.04 00590 OTHER A&G 5.05 -336, 279 20, 506, 040 5.05 5.06 00592 PATIENT TRANSPORTATION 599, 778 5.06 7.00 00700 OPERATION OF PLANT 0 17, 689, 620 7 00 00800 LAUNDRY & LINEN SERVICE 1.453.279 8.00 0 8.00 00900 HOUSEKEEPI NG 9 00 -180 5, 554, 383 9 00 10.00 01000 DI ETARY -21, 538 3, 532, 284 10.00 11.00 01100 CAFETERI A -861, 149 1, 868, 193 11.00 01300 NURSING ADMINISTRATION 3, 731, 317 13.00 13.00 -2.82814.00 01400 CENTRAL SERVICES & SUPPLY 1, 543, 510 14.00 01500 PHARMACY 15.00 -62, 624 5, 651, 117 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 -110, 736 2, 704, 155 16,00 01700 SOCIAL SERVICE 17 00 0 407, 414 17 00 01701 STAFF EDUCATION 17.01 0 17.01 01702 MEDICAL EDUCATION 17.02 0 44, 617 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 222, 850 21.00 22.00 |02200|1&R SERVICES-OTHER PRGM COSTS APPRVD 31, 168 22.00 23.00 02300 PARAMED ED PROGRAM -285, 312 526, 664 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS -9, 353, 271 33, 816, 212 30 00 31.00 03100 INTENSIVE CARE UNIT 7, 570, 845 31.00 03101 NEONATAL ICU 31.01 -1, 010, 425 1, 702, 035 31.01 1, 307, 560 04000 SUBPROVI DER - I PF 40.00 40.00 0 04100 SUBPROVI DER - I RF 41.00 0 3, 015, 506 41.00 43.00 04300 NURSERY 1, 492, 126 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n 6, 798, 358 50 00 05001 ENDOSCOPY 0 50.01 2, 592, 236 50.01 51.00 05100 RECOVERY ROOM 0 1, 155, 977 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 3, 264, 598 52.00 05300 ANESTHESI OLOGY 0 53 00 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 4,000,761 54.00 05401 RADI OLOGY - ULTRASOUND -5, 670 54.01 1,706,862 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C -9.671 2,023,298 55 00 05501 INFUSION CENTER 55.01 10,079 55.01 05600 RADI OI SOTOPE 1, 904, 332 56.00 56.00 57.00 05700 CT SCAN 1, 961, 793 57.00 -8, 679 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 1,009,193 58 00 59.00 05900 CARDIAC CATHETERIZATION 3, 387, 683 59.00 60.00 06000 LABORATORY -65, 356 9, 551, 220 60.00 06001 BLOOD LABORATORY 60.01 60.01 Ω 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS -72, 100 1, 407, 097 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 3, 216, 359 65 00 0 65 00 66.00 06600 PHYSI CAL THERAPY 0 1, 536, 609 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 279, 839 67.00 06800 SPEECH PATHOLOGY 0 68.00 516, 912 68.00 69.00 06900 ELECTROCARDI OLOGY 0 817, 915 69.00 06901 CARDI AC REHAB -119, 388 464, 787 69.01 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 144, 906 70.00 -663 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 11, 776, 424 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 045, 657 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS -331, 683 15, 539, 771 73.00 2, 074<u>, 635</u> 07400 RENAL DIALYSIS 74.00 74.00 OUTPATIENT SERVICE COST CENTERS

-450

0

-380, 925

-13, 299, 418

4, 515, 445

2, 499, 905

0

295, 805, 402

10, 320, 870

191. 00 19100 RESEARCH

09000 CLI NI C

09100 EMERGENCY

101.00 10100 HOME HEALTH AGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

SUBTOTALS (SUM OF LINES 1 through 117)

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

90.00

91.00

92.00

118.00

Health Financial Systems	METHODIST HOSPI	TALS, INC	In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provi der CCN: 15-0002	From 01/01/2019	Worksheet A  Date/Time Prepared: 6/25/2020 8:03 am

			6/25/2020 8:03 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	34, 651, 152	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	641, 955	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	214, 336	192.02
193. 00 19300 NONPALD WORKERS	0	0	193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-13, 299, 418	331, 312, 856	200.00

Provider CCN: 15-0002

| Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

					10	12/31/201	9 Date/lime Prepared: 6/25/2020 8:03 am
	Cost Center	Increases Line #	Sal ary	Other			
	2.00	3. 00	4. 00	5. 00			
	A - CAFETERIA						
1. 00	CAFETERI A	1100	<u>1, 290, 602</u>	<u>1, 154, 308</u>			1.00
	B - CLINICAL TRAINING COST		1, 290, 602	1, 154, 308			
1. 00	PARAMED ED PROGRAM	23. 00	266, 266	0			1.00
2. 00		0. 00	0	0			2. 00
3.00		0. 00	0	0			3.00
4. 00		0.00	0	0			4.00
5. 00 6. 00	1	0. 00 0. 00	Ol	0			5. 00 6. 00
0.00			266, 266	0			0.00
	C - SOCIAL WORKERS						
1.00	SOCI AL SERVI CE	<u>17.</u> 00	407, 414	0			1.00
	0		407, 414	0			
1. 00	E - RESIDENTS I &R SERVICES-SALARY &	21. 00	O	222, 850			1.00
1.00	FRI NGES APPRVD	21.00	٩	222, 030			1.00
2.00	I&R SERVICES-OTHER PRGM	22. 00	0	31, 168			2. 00
	COSTS APPRVD						
	U E MED SUDDLY		0	254, 018			
1. 00	F - MED SUPPLY MEDICAL SUPPLIES CHARGED TO	71. 00	ol	11, 776, 424			1.00
55	PATI ENTS		Ĭ	, . , 5, 121			1.00
2.00	IMPL. DEV. CHARGED TO	72. 00	O	10, 045, 657			2.00
2 00	PATI ENTS	0.00					2.00
3. 00 4. 00	1	0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	o	Ö			5.00
6.00		0.00	0	0			6. 00
7. 00		0. 00	0	0			7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0. 00	0	o			11.00
12. 00		0.00	o	0			12. 00
13.00		0.00	0	0			13.00
14.00		0. 00	0	0			14. 00
15.00		0.00	0	0			15.00
16. 00 17. 00		0. 00 0. 00	0	0			16. 00 17. 00
18. 00		0.00	o	Ö			18. 00
19. 00		0.00	o	0			19. 00
20.00		0.00	O	0			20.00
21. 00		0. 00	0	0			21.00
22. 00		0. 00 0. 00	0	0			22.00
23. 00 24. 00		0.00	ol Ol	0			23. 00 24. 00
25. 00		0.00	o	0			25. 00
26.00		0. 00	O	0			26. 00
27. 00		0. 00	0	0			27. 00
28. 00		0.00	0	0			28.00
29. 00 30. 00	1	0. 00 0. 00	0	0			29. 00 30. 00
31. 00		0.00	0	0			31.00
32. 00		0.00	o	0			32.00
33.00		0.00	O	0			33.00
34.00		0. 00	0	0			34.00
35.00		0.00	0	0			35.00
36. 00 37. 00		0. 00 0. 00	O O	0			36. 00 37. 00
38. 00		0.00	o	o			38.00
39.00		0. 00	ō	Ö			39. 00
40.00		0. 00	О	0			40.00
41. 00		0.00	•	0			41.00
	G - LIGHT DUTY		0	21, 822, 081			
1. 00	HOUSEKEEPI NG	9. 00	126	0			1.00
2. 00	DI ETARY	10. 00	4, 717	Ö			2.00
3.00	NURSING ADMINISTRATION	13. 00	2, 088	0			3.00
4. 00	ADULTS & PEDIATRICS	30. 00	12, 194	0			4.00
5.00	OPERATING ROOM	50.00	31, 540	0			5.00
	DELIVERY ROOM & LABOR ROOM	52. 00	699	0			6. 00
6. 00 7. 00	RESPI RATORY THERAPY	65. 00	3, 736	0			7.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Provider CCN: 15-0002

					/25/2020 8: 03 am
		Increases			
	Cost Center	Li ne #	Sal ary	Other 5.00	
	2. 00 H - INTEREST EXPENSE	3. 00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	ol	3, 116, 715	1.00
2. 00	TOTAL REE GOOTS BEBU & TTAT	0.00	Ö	0	2.00
3. 00		0.00	o	O	3.00
4.00		0.00	О	0	4. 00
5.00		0.00	O	0	5.00
6. 00		0. 00	0	0	6.00
7. 00	<u> </u>	0.00	0	0	7. 00
	O CORRODATE EVENUE		0	3, 116, 715	
1. 00	I - CORPORATE EXPENSE CAP REL COSTS-BLDG & FLXT	1.00	0	6, 140, 067	1.00
2. 00	OPERATION OF PLANT	7. 00	0	4, 387, 660	2.00
2.00	0		ŏ	10, 527, 727	2.00
	J - DRUG EXPENSE	,	-		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	14, 212, 529	1.00
2.00		0. 00	0	0	2. 00
3.00		0.00	•	0	3. 00
	O		0	14, 212, 529	
1 00	K - PHYSICIAN RECLASS OTHER A&G	5. 05	O	39, 950	1.00
1. 00 2. 00	CLINIC	90.00	0	48, 065	2.00
2.00			- — — <del>ў</del>	88, 015	2.00
	L - PSTD RECLASS		<u> </u>	00, 010	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	288, 714	1.00
2.00		0. 00	0	0	2.00
3.00		0.00	О	0	3.00
4. 00		0. 00	0	0	4.00
5. 00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7. 00 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00	ol Ol	0	9.00
10.00		0.00	0	0	10.00
11. 00		0.00	o	Ö	11.00
12. 00		0.00	o	Ö	12.00
13.00		0.00	O	0	13. 00
14.00		0.00	О	0	14. 00
15.00		0.00	0	0	15. 00
16.00		0. 00	0	0	16. 00
17. 00		0. 00	0	0	17. 00
18. 00		0. 00	0	0	18. 00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21. 00 22. 00	+	0. 00 0. 00	0	0	21. 00 22. 00
23. 00		0.00	o	0	23.00
24. 00		0.00	o	0	24.00
25. 00		0. 00	ő	Ö	25. 00
26. 00		0.00	o	O	26. 00
27.00		0.00	0	0	27. 00
28. 00		0.00	0	0	28. 00
29.00		0.00	0	0	29. 00
30.00		<u>0.</u> 00	0	0	30.00
	M DEDDECLATION DECLACE		0	288, 714	
1 00	M - DEPRECIATION RECLASS	1 00	ما	11 704 220	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	1. 00 0. 00	0	11, 786, 320	1. 00 2. 00
2. 00 3. 00	1	0.00	ol Ol	0	3.00
4. 00		0.00	0	0	4.00
5. 00		0.00	0	Ö	5.00
6. 00		0.00	Ö	Ö	6. 00
7. 00		0.00	O	0	7. 00
8.00		0.00	0	0	8. 00
9. 00		0. 00	0	0	9. 00
10.00		0.00	0	0	10.00
11. 00		0. 00	0	0	11.00
12.00		0. 00	0	0	12.00
13.00		0. 00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
17. 00 18. 00	1	0.00	0	0	17.00
19. 00		0.00	0	0	19. 00
17.00	1	0.00	J	0	 17.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Provider CCN: 15-0002

							6/25/2020 8: (	03 am
2.00								
20.00			Li ne #					
21.00		2. 00		4. 00				
22.00 23.00 24.00 24.00 25.00 26.00 0.00 0.00 0.00 0.00 0.00 22.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 29.00 29.00 29.00 29.00 30.00 30.00 31.00 32.00 33.00 31.00 32.00 33.00 31.00 32.00 33.00 31.00 32.00 33.00 34.00 34.00 35.00 34.00 35.00 36.00 37.00 36.00 37.00 38.00 37.00 38.00 38.00 38.00 39.00 40.00 0.00 0.00 0.00 0.00 0.00 0.00				0				
23.00   0.00   0.00   0   0   22.00   25.00   0.00   0.00   0   0   0   27.00   0.00   0.00   0   0   27.00   0.00   0.00   0   0   28.00   0.00   0.00   0   0   28.00   0.00   0.00   0   0   28.00   0.00   0.00   0   0   28.00   0.00   0.00   0   0   29.00   0.00   0.00   0   30.00   0.00   0   0   31.00   0.00   0   0   32.00   0.00   0   0   32.00   0.00   0   0   33.00   0.00   0   33.0								
24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 32. 00 33. 00 34. 00 34. 00 34. 00 35. 00 36. 00 37. 00 38				0	0			
25. 00	23.00			0				23.00
26. 00				0	0			24. 00
27.00	25.00		0. 00	0	0			25. 00
28. 00	26.00		0.00	0	0			26.00
29.00	27.00		0.00	0	0			27.00
30.00	28.00		0.00	o	0			28. 00
31.00	29.00		0.00	o	0			29.00
31.00	30.00		0.00	o	0			30.00
33.00	31.00		0.00	O	0			
34, 00	32.00		0.00	O	0			32.00
35.00	33.00		0.00	O	0			33.00
36.00	34.00		0.00	O	0			34.00
37.00	35.00		0.00	O	0			35.00
37.00	36.00		0.00	0	0			36.00
39.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 41.00 42.00 43.00 43.00 44.00 45.00 46.00 46.00 46.00 46.00 47.00 48.00 49.00  N - DEPT 9101 RECLASS  O - UTILLITIES RECLASS  O - UTILLITI	37.00		0.00	0				37.00
40.00 41.00 42.00 42.00 43.00 43.00 44.00 43.00 44.00 44.00 44.00 45.00 45.00 46.00 47.00 46.00 47.00 48.00 48.00 49.00  0	38.00		0.00	0	0			38. 00
41.00	39.00		0.00	0	0			39.00
42.00	40.00		0.00	0	0			40.00
43.00	41.00		0.00	O	0			41.00
44.00	42.00		0.00	O	0			42.00
44.00	43.00		0.00	O	0			43.00
45. 00 46. 00 46. 00 47. 00 48. 00 49. 00  0	44.00			O				44.00
47. 00 48. 00 49. 00  0	45.00		0.00	O				45.00
48.00 49.00  0 0 0 0 0 0 49.00  N - DEPT 9101 RECLASS  1.00 PHYSICIANS' PRI VATE OFFICES 192.00 252,081 21,353 0 0 - UTILITIES RECLASS  1.00 OPERATION OF PLANT 7.00 0 802,639 1.00 2.00 3.00 0.00 0 0 0 2.00 3.00 4.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46.00		0.00	o	0			46.00
48.00 49.00  0 0 0 0 0 0 49.00  N - DEPT 9101 RECLASS  1.00 PHYSICIANS' PRI VATE OFFICES 192.00 252,081 21,353 0 0 - UTILITIES RECLASS  1.00 OPERATION OF PLANT 7.00 0 802,639 1.00 2.00 3.00 0.00 0 0 0 2.00 3.00 4.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47.00		0.00	o	0			47.00
1.00   N - DEPT 9101 RECLASS   192.00   252.081   21.353   0   252.081   21.353   0   0   0   0   0   0   0   0   0	48.00			o	0			48. 00
1. 00   N - DEPT 9101 RECLASS   192.00   252.081   21.353   0   252.081   21.353   0   0   0   0   0   0   0   0   0	49.00		0.00	o	0			49. 00
N - DEPT 9101 RECLASS		0			11, 786, 320			
1.00		N - DEPT 9101 RECLASS						
1.00	1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	252, 081	21, 353			1.00
1. 00 OPERATI ON OF PLANT 7. 00 0 802, 639 1. 00 2. 00 3. 00 0. 00 0 0 0 0 4. 00 0. 00 0 0 0 5. 00 0. 00 0 0 0 6. 00 1. 00 0		0		252, 081	21, 353			
2. 00 3. 00 4. 00 5. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
3. 00 4. 00 5. 00 6. 00	1.00	OPERATION OF PLANT		0	802, 639			1.00
4. 00 5. 00 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00		0.00	0	0			2.00
5. 00 6. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0	3.00		0.00	0	0			3.00
6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00		0.00	o	0			4.00
6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00			o	0			5.00
0 0 802, 639  P - C SECTI ON RECLASS  1. 00 OPERATI NG ROOM 50. 00 40, 437 0 1. 00  TOTALS 40, 437 0	6.00		0.00	o	0			
1. 00 OPERATI NG ROOM 50. 00 40, 437 0 1. 00 TOTALS 40, 437 0		0			802, 639			]
TOTALS 40, 437 0		P - C SECTION RECLASS						]
	1.00	OPERATING ROOM	50.00	40, 437	0			1.00
		TOTALS		40, 437	_			1
	500.00	Grand Total: Increases		2, 311, 900				500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

Septimatory   Herapay   65.00   16.834   0   0   0   6.00   0   0   0   0   0   0   0   0   0							6/25/2020 8:	
A CAPTERIA								
1.00								
DELFARY   10,00   1,290,602   1,194,308   0   0   1,000   0   1,			7. 00	8. 00	9. 00	10.00		
O	1 00		10.00	1 200 402	1 154 200			1 00
B	1.00	DIETARY		+				1.00
ADDITION		B - CLINICAL TRAINING COST		1, 290, 002	1, 154, 500			
0.00     0.00	1 00		30.00	13 148	0	0		1 00
2.00   CARDI RC CATHETER ZATION   0   0   0   0   0   0   0   0   0								1
LABORATORY   Co. 00   12, 607   0   0   0   5.00   6.00								1
Signature   Sign			1		0	0		4.00
C	5.00	RESPI RATORY THERAPY			0	0		5.00
C - SOCI AL MORRERS	6.00	EMERGENCY	91.00	204, 765	0	0		6.00
1.00		0 — — — — —		266, 266				
1.00		C - SOCIAL WORKERS						
E - RESIDEMIS 1.00	1.00	OTHER A&G						1.00
1.00		0		407, 414	0			
2.00								
1.00   DIRCHASTING RECEIVING AND   5.02   0   105,684   0   1.00   20   0   2.00   3		EMERGENCY		1				
F - MED SUPPLY	2.00							2.00
1.00   DURCHASTING RECELVING AND   5.02   0   105, 684   0   1.00   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   3.00   0.00		O LE MED CHEDI V		<u> </u>	254, 018			
STORES 3.00 OFFICE ASK 3.00 OF	1 00		E 02	٥	105 (04			1 00
2.00 ADMITTING	1.00	1	5. 02	o <sub>l</sub>	105, 684	U		1.00
3.00 OTHER AGC	2 00		5 02		20			2 00
4.00								1
5.00   HOUSEKEEPING   9,00   0   4,127   0   5.00   6.00   1.1248Y   10.00   0   18   0   6.00   0.1248Y   10.00   0   6.93   0   7.00   18   0   6.00   0.1248Y   10.00   0   6.93   0   7.00   1.00   0.00								1
6.00   0   ETARY   10.00   0   18   0   7.00   0   8.00   0.693   0   7.00   0   0   0   0   0   0   0   0   0								•
7. 00 NURSING ADMINISTRATION			1		•			
B. 00         CENTRAL SERVICES & SUPPLY         14.00         0         127,640         0         9.00           10. 00         MEDICAL RECORDS & LIBRARY         16.00         0         88.800         0         9.00           11. 00         MEDICAL RECORDS & LIBRARY         16.00         0         26         0         110.00           12. 00         PARAMED ED PROGRAM         23.00         0         171         0         12.00           13. 00         ADUSTS & PEDIATRIC S         30.00         0         484,371         0         13.00           14. 00         INTENSI VE CARE LIMIT         31.00         0         153,328         0         14.00           16. 00         SUBPROVIDER - IRE         41.00         0         39,640         0         16.00           16. 00         SUBPROVIDER - IRE         41.00         0         39,640         0         17.00           18. 00         OPERATING ROM         50.00         0         12,709,157         0         18.00           19. 00         PROSOCEPY         50.01         0         22,363         0         19.00           20. 00         RECOVERY ROOM         51.00         0         3,344         0         22.00				-				1
9.00 PHARMACY		1		- 1				1
10.00   MEDICAL RECORDS & LIBRARY   16.00   0   26   0   11.00   11.00   12.00   148   0   11.00   12.00   148   0   11.00   12.00   148   0   12.00   13.00   13.00   14.00   13.00   14.00   15.00		•		-				
12. 00   PARAMED ED PROCRAM   23. 00   0   171   0   12. 00   13. 00   14. 00   171   0   13. 00   13. 00   14. 00   171   0   171   0   13. 00   14. 00   171   13. 00   153. 328   0   14. 00   15. 00				0				1
13. 00   ADULTS & PEDIATRICS   30. 00   484, 371   0   13. 00   15. 00   17. 00	11.00	MEDICAL EDUCATION	17. 02	0	148	o		11.00
14. 00   INTENSIVE CARE UNIT   31. 00   0   153. 328   0   14. 00   15. 0	12.00	PARAMED ED PROGRAM		0	171	o		12.00
15.00   NEONATAL ICU	13.00	ADULTS & PEDIATRICS	30.00	O	484, 371	0		13.00
16. 00   SUBPROVI DER - I RF	14.00	INTENSIVE CARE UNIT	31.00	O	153, 328	0		14.00
17. 00   NURSERY	15.00	NEONATAL ICU	31. 01	0	509	0		15.00
18. 00   OPERATING ROOM   50. 00   0   12,709, 157   0   18. 00   19. 00   19. 00   ENDOSCOPY   50. 01   0   272, 363   0   19. 00   20. 00   RECOVERY ROOM   51. 00   0   9,334   0   21. 00   0   21. 00   0   21. 00   0   21. 00   0   21. 00   0   21. 00   0   21. 00   0   21. 00   0   22. 00   23. 00   24. 00   24. 00   22. 00   23. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   25. 00   0   25. 00   0   25. 00   0   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   26. 00   26. 00   27. 00   26. 00   27. 00   26. 00   27. 00	16.00		41. 00		39, 640			16.00
19. 00   ENDOSCOPY   50. 01   0   272, 363   0   19. 00   20. 00								1
20. 00   RECOVERY ROOM   51. 00   0   9, 334   0   22. 00			1	1				1
21. 00   DELIVERY ROOM & LABOR ROOM   52. 00   0   33.614   0   22. 00   22. 00   23. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   2.6444   0   22. 00   23. 00   23. 00   24. 00   RADI OLOGY-ULTRASOUND   54. 01   0   33. 553   0   23. 00   24. 00   RADI OLOGY-THERAPEUTI C   55. 00   0   16. 857   0   24. 00   25. 00   26. 00   CT SCAN   57. 00   0   419   0   25. 00   26. 00   27. 00   MAGNETI C RESONANCE I MAGI NG   57. 00   0   45. 376   0   26. 00   27. 00   MAGNETI C RESONANCE I MAGI NG   59. 00   0   247   0   27. 00   MAGNETI C RESONANCE I MAGI NG   59. 00   0   247   0   27. 00   28. 00   29			1					4
22.00   RADI OLOGY - DI AGNOSTI C   54.00   0   2.644   0   0   23.00   23.00   RADI OLOGY - ULTRASOUND   54.01   0   33.553   0   23.00   23.00   24.00   RADI OLOGY - HERAPEUTI C   55.00   0   16.857   0   24.00   25.00   RADI OLOGY - THERAPEUTI C   55.00   0   419   0   25.00   24.00   25.00   26.00   27.00   MAGNETI C RESONANCE I MAGI NG   58.00   0   45.376   0   27.00   27.00   MAGNETI C RESONANCE I MAGI NG   58.00   0   45.376   0   27.00   27.00   27.00   MAGNETI C RESONANCE I MAGI NG   58.00   0   45.376   0   27.00   27.00   28.00   28.00   28.00   28.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00								
23. 00   RADI OLLOGY - ULTRASQUIND			1					
24.00 RADI OLOGY-THERAPEUTI C 55.00 0 16,857 0 22.00 25.00 RADI OLOGY-THERAPEUTI C 55.00 0 1419 0 25.00 25.00 RADI OLOGY-THERAPEUTI C 55.00 0 419 0 25.00 25.00 CT SCAN 57.00 0 45,376 0 26.00 CT SCAN 57.00 0 45,376 0 26.00 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 2447 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 2447 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 2447 0 27.00 MAGNETI C RESONANCE I MAGI NG 58.00 0 38.00 MAGNETI C RESONANCE I MAGI NG 18.00 0 27.00 0 28.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 0 246,385 0 29.00 0 30.00 MAGNETI C RESONANCE I MAGI NG 78.00 0 246,385 0 0 31.00 RESPI RATORY THERAPY 66.00 0 0 419 0 0 32.00 32.00 PHYSI CAL THERAPY 66.00 0 0 419 0 0 32.00 33.00 RESPI RATORY THERAPY 66.00 0 0 8,191 0 0 33.00 0 34.00 CARDI ACREHAB 69.01 0 933 0 34.00 CARDI ACREHAB 69.01 0 0 27.422.005 0 35.00 36.00 DRUGS CHARGED TO PATI ENTS 73.00 0 228,282 0 36.00 36.00 DRUGS CHARGED TO PATI ENTS 73.00 0 228,282 0 36.00 37.00 RENAL DI ALYSI S 74.00 0 16.8821 0 37.00 A0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	1					1
25.00 RADI OI SOTOPE 56.00 0 419 0 25.00 26.00 CT SCAN 57.00 0 45,376 0 26.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 247 0 27.00 RAGNETI C RESONANCE I MAGI NG 58.00 0 246.00 0 248.00 249.00 RESON RESON RESONANCE RED 62.00 0 15.5533 0 29.00 RESON RESPIRATORY THERAPY 66.00 0 118 0 30.00 RESPIRATORY THERAPY 66.00 0 419 0 32.00 RESPIRATORY THERAPY 66.00 0 419 0 33.00 RESPIRATORY THERAPY 66.00 0 419 0 33.00 RESPIRATORY THERAPY 66.00 0 33.00 RESPIRATORY THERAPY 66.00 0 34.19 0 33.00 RESPIRATORY THERAPY 66.00 0 34.19 0 33.00 RESPIRATORY THERAPY 70.00 0 8.191 0 33.00 RESPIRATORY THERAPY 70.00 0 2.742.005 0 33.00 RESPIRATORY THERAPY 70.00 0 2.742.005 0 33.00 RESPIRATORY THERAPY 70.00 0 2288.282 0 36.00 RESPIRATORY THERAPY 70.00 0 2288.282 0 36.00 RESPIRATORY THERAPY 70.00 0 16.8821 0 36.00 RESPIRATORY THERAPY 70.00 0 16.8821 0 36.00 RESPIRATORY THERAPY 70.00 0 18.911 0 38.00 RESPIRATORY THERAPY 70.00 0 18.911 0 38.00 RESPIRATORY THERAPY 70.00 0 18.911 0 38.00 RESPIRATORY 70.00 0 18.911 0 39.00 RESPIRATORY 70.00 0 18.911 0 38.00 RESPIRATORY 70.00 0 18.911 0 38.00 RESPIRATORY 70.00 0 18.911 0 38.00 RESPIRATORY 70.00 0 18.911 0 0 39.00 RESPIRATORY 70.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			· · · · · · · · · · · · · · · · · · ·					1
26.00 CT SCAN 27.00 MAGNETIC RESONANCE IMAGING (MRI) 28.00 CARDIAC CATHETERIZATION 29.00 LABORATORY 60.00 O 3,869,601 0 29.00 10.00 MESPI RATORY THERAPY 65.00 O 246,385 0 11.00 RESPI RATORY THERAPY 65.00 O 31.00 RESPI RATORY THERAPY 65.00 O 32.00 PHYSI CAL THERAPY 66.00 O 33.00 ELECTROCARDIOLOGY 69.00 O 33.00 ELECTROCARDIOLOGY 69.00 O 33.00 ELECTROCARDIOLOGY 69.00 O 33.00 ELECTROCARDIOLOGY 69.00 O 35.00 ELECTROCARDIOLOGY 69.00 O 35.00 ELECTROEOEPHALOGRAPHY 70.00 O 27.742,005 0 37.00 RENAL DIALYSIS 74.00 O 16.88,21 0 38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			· · · · · · · · · · · · · · · · · · ·					
27. 00 MAGNETIC RESONANCE IMAGING (MRI)  28. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 3,869,601 0 28. 00  29. 00 LABORATORY 60. 00 0 15,533 0 29. 00  30. 00 WHOLE BLOOD & PACKED RED 62. 00 0 118 0 30. 00  BLOOD CELLS  31. 00 RESPI RATORY THERAPY 65. 00 0 246,385 0 31. 00  32. 00 PHYSI CAL THERAPY 66. 00 0 8, 191 0 33. 00  44. 00 CARDI AC REHAB 69. 01 0 933 0 34. 00  36. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 228, 282 0 36. 00  37. 00 RENAL DI ALYSIS 74. 00 0 1,634 0 37. 00  39. 00 EMERGENCY 91. 00 0 168, 821 0 38. 00  39. 00 EMERGENCY 91. 00 0 144, 971 0 40. 00  41. 00 PHYSI CAL THERAPY 100 0 0 1,80,12 0 0 100  41. 00 PHYSI CAL THERAPY 70. 00 0 1,80,12 0 0 100  39. 00 CARDI AC REHAB 69. 01 0 9. 00 0 168, 821 0 38. 00  39. 00 EMERGENCY 91. 00 0 144, 971 0 40. 00  41. 00 PHYSI CLANS' PRI VATE OFFI CES 192. 00 0 78, 012 0 0 18. 00  30. 00  30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					1
MRI   CARDI AC CATHETERI ZATI ON			1	-1				1
28. 00	27.00		30.00	٩	247			27.00
29.00   LABORATORY   60.00   0   15,533   0   29.00   30.00   WHOLE BLOOD & PACKED RED   62.00   0   118   0   8   100   CELLS	28. 00		59. 00	0	3, 869, 601	0		28.00
30. 00   WHOLE BLOOD & PACKED RED   62. 00   0   118   0   30. 00								
31. 00 RESPIRATORY THERAPY 65. 00 0 246, 385 0 32. 00 32. 00 32. 00 PHYSI CAL THERAPY 66. 00 0 419 0 32. 00 33. 00 ELECTROCARDI OLOGY 69. 00 0 8, 191 0 0 33. 00 34. 00 CARDI AC REHAB 69. 01 0 933 0 0 34. 00 35. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 2, 742, 005 0 35. 00 36. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 228, 282 0 36. 00 37. 00 RENAL DI ALYSI S 74. 00 0 168, 821 0 37. 00 38. 00 CLI NI C 90. 00 0 168, 821 0 38. 00 39. 00 EMERGENCY 91. 00 0 14, 971 0 40. 00 41. 00 PHYSI CLI ANS' PRI VATE OFFI CES 192. 00 0 21, 822, 081 0 33. 00 6 - LI GHT DUTY  1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 55, 100 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0				1				30.00
32. 00 PHYSI CAL THERAPY 66. 00 0 419 0 32. 00 33. 00 ELECTROCARDI OLOGY 69. 00 0 8, 191 0 33. 00 34. 00 CARDI AC REHAB 69. 01 0 933 0 34. 00 35. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 2, 742, 005 0 35. 00 36. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0 228, 282 0 36. 00 37. 00 RENAL DI ALYSI S 74. 00 0 168, 821 0 37. 00 38. 00 CLI NI C 90. 00 168, 821 0 38. 00 39. 00 EMERGENCY 91. 00 0 285, 770 0 39. 00 41. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 21, 822, 081 0 41. 00  C - LI GHT DUTY								
33. 00   ELECTROCARDI OLOGY   69. 00   0   8, 191   0   33. 00   34. 00   34. 00   2ARDI AC REHAB   69. 01   0   933   0   34. 00   35. 00   ELECTROENCEPHALOGRAPHY   70. 00   0   2, 742, 005   0   35. 00   36. 00   DRUGS CHARGED TO PATI ENTS   73. 00   0   228, 282   0   36. 00   37. 00   RENAL DI ALYSI S   74. 00   0   1, 634   0   37. 00   38. 00   CLI NI C   90. 00   0   168, 821   0   38. 00   39. 00   EMERGENCY   91. 00   0   285, 770   0   39. 00   40. 00   HEALTH AGENCY   101. 00   0   14, 971   0   40. 00   41. 00   PHYSI CI ANS' PRI VATE OFFI CES   192. 00   0   21, 822, 081   0   3. 00   4. 00   3. 00   4. 00   4. 00   4. 00   5. 00   0   0   0   0   0   0   0   0   0	31.00		65. 00	О	246, 385	0		31.00
34. 00 CARDI AC REHAB 69. 01 0 933 0 34. 00 35. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 2, 742, 005 0 35. 00 36. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 228, 282 0 36. 00 37. 00 RENAL DI ALYSI S 74. 00 0 1, 634 0 37. 00 38. 00 CLI NI C 0 90. 00 168, 821 0 38. 00 39. 00 EMERGENCY 91. 00 0 285, 770 0 39. 00 40. 00 HOME HEALTH AGENCY 101. 00 0 14, 971 0 40. 00 41. 00 PHYSI CI ANS' PRI VATE OFFICES 192. 00 0 21, 822, 081 0 41. 00  2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				О				32.00
35.00   ELECTROENCEPHALOGRAPHY   70.00   0   2,742,005   0   35.00   36.00   DRUGS CHARGED TO PATIENTS   73.00   0   228,282   0   36.00   37.00   RENAL DIALYSIS   74.00   0   1,634   0   37.00   38.00   CLI NIC   90.00   0   168,821   0   38.00   39.00   EMERGENCY   91.00   0   285,770   0   39.00   41.00   HOME HEALTH AGENCY   101.00   0   14,971   0   40.00   41.00   PHYSICIANS' PRIVATE OFFICES   192.00   0   78,012   0   0   21,822,081   0   0   2.00   3.00   4.00   4.00   4.00   4.00   4.00   4.00   4.00   6.00   6.00   6.00   6.00   6.00   6.00   7.00   0   0   0   0   0   0   0   0   0				O				33.00
36. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 228, 282 0 36. 00 37. 00 RENAL DI ALYSI S 74. 00 0 1, 634 0 37. 00 38. 00 CLI NI C 90. 00 0 168, 821 0 38. 00 39. 00 EMERGENCY 91. 00 0 285, 770 0 39. 00 40. 00 HOME HEALTH AGENCY 101. 00 0 14, 971 0 40. 00 41. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 21, 822, 081 0 39. 00 41. 00 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 55, 100 0 0 0 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0				0				34.00
37. 00 RENAL DIALYSIS 74. 00 0 1, 634 0 37. 00 38. 00 CLINIC 90. 00 0 168, 821 0 38. 00 39. 00 EMERGENCY 91. 00 0 285, 770 0 40. 00 40. 00 HOME HEALTH AGENCY 101. 00 14, 971 0 40. 00 41. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 78, 012 0 G - LIGHT DUTY  1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 55, 100 0 0 1. 00 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				35.00
38. 00		1		0				36.00
39. 00   EMERGENCY   91. 00   0   285, 770   0   39. 00   40. 00   HOME HEALTH AGENCY   101. 00   0   14, 971   0   0   0   14. 00   0   14. 971   0   0   0   0   0   0   0   0   0				0				37.00
40.00 HOME HEALTH AGENCY 101.00 0 14,971 0 40.00 41.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 78,012 0 41.00  G - LIGHT DUTY  EMPLOYEE BENEFITS DEPARTMENT 4.00 55,100 0 0 0 1.00 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				38. 00
41. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 78, 012 0 0 21, 822, 081 0 0 0 21, 822, 081 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1						1
0				0				
G - LIGHT DUTY  1. 00 EMPLOYEE BENEFITS DEPARTMENT	41. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0				41.00
1. 00 EMPLOYEE BENEFITS DEPARTMENT		C LICUT DUTY		0	21, 822, 081			-
2. 00     0.00     0     0     0     0     0     3. 00       3. 00     0. 00     0     0     0     0     3. 00       4. 00     0. 00     0     0     0     0     4. 00       5. 00     0. 00     0     0     0     0     5. 00       6. 00     0. 00     0     0     0     0     6. 00       7. 00     0     0     0     0     0     7. 00	1 00		4 00	FF 100	^			1 00
3.00     0.00		EMPLUYEE BENEFI IS DEPARIMENT		· · · · · · · · · · · · · · · · · · ·				
4. 00       5. 00       6. 00       7. 00				- 1	-			
5. 00     0.00     0     0     0     5. 00       6. 00     0.00     0     0     0     6. 00       7. 00     0.00     0     0     0     0				- 1	0			1
6. 00				ĭ.	0			4
7.00 0 0_ 7.00					-			
				0	0			
	50				— — <u> </u>			7.00
			I	237.00	0	1		T

Provider CCN: 15-0002

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/25/2020 8: 03 am

		Decreases				6/25/2020 8:	US alli
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10.00		
	H - INTEREST EXPENSE						
1.00	OTHER A&G	5. 05	0	1, 585, 803	11		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	115, 716			2. 00
3.00	RADI OLOGY - ULTRASOUND	54. 01	0	57, 858			3. 00
4. 00	CT SCAN	57. 00	0	57, 858			4. 00
5. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	57, 858	0		5. 00
4 00	(MRI)	102.00		191	0		4 00
6. 00 7. 00	PHYSICIANS' PRIVATE OFFICES OTHER NON-REIMBURSABLE	192. 00 192. 01	0	1, 241, 431			6. 00 7. 00
7.00	OTHER NON-RETWIBURSABLE	<u> </u>	— — —	3, 116, 715			7.00
	I - CORPORATE EXPENSE		<u> </u>	3, 110, 713			-
1. 00	OTHER A&G	5. 05	O	10, 527, 727	9		1.00
2. 00	James 7 Mag	0.00	Ö	0	Ó		2.00
			— — — ō	10, 527, 727			
	J - DRUG EXPENSE	•					Ī
1.00	PHARMACY	15. 00	0	7, 749, 771			1.00
2.00	ELECTROENCEPHALOGRAPHY	70. 00	0	6, 457, 604			2. 00
3. 00	INFUSION CENTER	<u>55.</u> 01	0	<u>5, 1</u> 54			3. 00
	0		0	14, 212, 529			_
1 00	K - PHYSICIAN RECLASS	102.00	٥	00.015			1 00
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00 0. 00	0	88, 015	0		1.00
2. 00		— — <del>0.00</del>	— — —	88, 015			2. 00
	L - PSTD RECLASS		U <sub>I</sub>	66,015			-
1. 00	PURCHASING RECEIVING AND	5. 02	3, 299	0	0		1.00
	STORES	0.02	0,2,,	· ·			1
2.00	ADMI TTI NG	5. 03	5, 120	0	0		2. 00
3.00	CASHI ERI NG/ACCOUNTS	5. 04	3, 220	0	0		3.00
	RECEI VABLE		·				
4.00	OTHER A&G	5. 05	28, 533	0	0		4. 00
5.00	PATIENT TRANSPORTATION	5. 06	1, 655	0	0		5. 00
6.00	OPERATION OF PLANT	7. 00	9, 268	0	0		6. 00
7.00	HOUSEKEEPI NG	9. 00	27, 249	0	0		7. 00
8.00	DI ETARY	10. 00	5, 787	0	0		8. 00
9.00	CAFETERI A	11. 00	3, 116	0	0		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	3, 882	0			10.00
11. 00	ADULTS & PEDIATRICS	30. 00	31, 693	0			11. 00
12.00	INTENSIVE CARE UNIT	31. 00	17, 734	0			12. 00
13.00	SUBPROVI DER - I PF	40. 00	6, 147	0			13.00
14.00	SUBPROVI DER - I RF	41. 00	6, 468	0	-		14.00
15. 00	NURSERY	43. 00	4, 122	0			15. 00
16.00	OPERATING ROOM	50.00	6, 418	0			16.00
17.00	ENDOSCOPY	50. 01	3, 240	0			17.00
18.00	RECOVERY ROOM	51.00	1, 811	0			18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	7, 715	0			19.00
20. 00 21. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND	54. 00 54. 01	8, 145 1, 524	0	0		20. 00 21. 00
	CT SCAN	57. 00	6, 286	0	0		22.00
	CARDI AC CATHETERI ZATI ON	59.00	9, 090	0			23. 00
24. 00	LABORATORY	60.00	3, 268	0	١		24.00
25. 00	WHOLE BLOOD & PACKED RED	62.00	918	0			25. 00
20.00	BLOOD CELLS	02.00	,10	O			20.00
26.00	RESPI RATORY THERAPY	65. 00	922	0	0		26. 00
27. 00	CLINIC	90.00	4, 776	0	0		27. 00
28. 00	EMERGENCY	91. 00	6, 500	0	0		28. 00
29. 00	HOME HEALTH AGENCY	101.00	1, 419	0	0		29. 00
30.00	PHYSICIANS' PRIVATE OFFICES	192. 00	69, 389	0	0		30.00
	0 — — — — —		288, 714				_
	M - DEPRECIATION RECLASS						
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9, 827	9		1.00
2.00	DATA PROCESSING	5. 01	0	2, 072, 072			2. 00
3.00	PURCHASING RECEIVING AND	5. 02	0	37, 056	0		3. 00
	STORES	5 00		4 (00			
4. 00	ADMITTING	5. 03	0	1, 639			4.00
5. 00	CASHI ERI NG/ACCOUNTS	5. 04	O	4, 374	0		5. 00
6 00	RECEI VABLE	5. 05		200 405	0		6.00
6. 00 7. 00	OTHER A&G PATIENT TRANSPORTATION	5. 05	0	309, 685 19, 755			6. 00 7. 00
7. 00 8. 00	OPERATION OF PLANT	7.00	0	19, 755 435, 459			8.00
9. 00	HOUSEKEEPI NG	9. 00	0	435, 459 63, 831			9.00
	DI ETARY	10. 00	0	73, 149			10.00
11. 00	CAFETERI A	11. 00	0	73, 149 551			11.00
	NURSING ADMINISTRATION	13. 00	o	54, 459	-		12.00
	CENTRAL SERVICES & SUPPLY	14. 00	0	279, 871			13.00
	1	30	٩	2, 37.1	·		

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/25/2020 8:03 am Provider CCN: 15-0002

						6/25/2020 8:0	03 am
		Decreases				ı	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
14.00	PHARMACY	15. 00	0	144, 840			14.00
15.00	MEDICAL RECORDS & LIBRARY	16. 00	0	6, 504	0		15.00
16.00	PARAMED ED PROGRAM	23. 00	0	4, 320	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	229, 507	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	o	547, 973	O		18.00
19.00	NEONATAL I CU	31. 01	o	34, 282	O		19.00
20.00	SUBPROVI DER - I PF	40. 00	0	10, 350	o		20.00
21.00	SUBPROVI DER - I RF	41.00	o	9, 192	o		21.00
22.00	NURSERY	43.00	0	66, 276	0		22.00
23. 00	OPERATING ROOM	50. 00	0	854, 516	O		23. 00
24. 00	ENDOSCOPY	50. 01	0	73, 818	o		24.00
25. 00	RECOVERY ROOM	51. 00	O O	1, 277	o	l l	25. 00
26. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	114, 409	o		26.00
27. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	778, 208	o	l l	27.00
28. 00	RADI OLOGY - ULTRASOUND	54. 01	0	426, 955	o		28.00
	RADI OLOGY - DETRASOUND RADI OLOGY-THERAPEUTI C		0		0		1
29. 00		55. 00	O O	738, 434		l l	29.00
30.00	RADI OI SOTOPE	56. 00	0	240, 306	0	l I	30.00
31.00	CT SCAN	57. 00	0	431, 524	0	l e	31.00
32. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	685, 883	0		32. 00
	(MRI)	50.00		450.050			
33. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	453, 952	0		33.00
34.00	LABORATORY	60. 00	0	43, 896	0	l e	34.00
35.00	WHOLE BLOOD & PACKED RED	62. 00	0	8, 781	0		35. 00
	BLOOD CELLS						
36. 00	RESPI RATORY THERAPY	65. 00	0	71, 411	0	l e	36. 00
37.00	PHYSI CAL THERAPY	66. 00	0	1, 733	0	l e	37.00
38.00	OCCUPATI ONAL THERAPY	67. 00	0	442	0	l .	38. 00
39. 00	SPEECH PATHOLOGY	68. 00	0	2, 005	0		39. 00
40.00	ELECTROCARDI OLOGY	69. 00	0	180, 846	0		40.00
41.00	CARDI AC REHAB	69. 01	0	167, 338	0		41.00
42.00	ELECTROENCEPHALOGRAPHY	70. 00	0	118, 149	0		42.00
43.00	DRUGS CHARGED TO PATIENTS	73. 00	0	27, 927	o		43.00
44.00	CLINIC	90. 00	o	165, 430	o		44.00
45.00	EMERGENCY	91.00	0	345, 859	0		45.00
46. 00	HOME HEALTH AGENCY	101. 00	0	1, 134	0		46.00
47. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	1, 153	0		47. 00
17.00	CANTEEN CANTEE SHOLL	170.00	Ĭ	1, 100			17.00
48. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	754, 789	0		48. 00
49. 00	OTHER NON-REIMBURSABLE	192. 01	Ö	681, 173		l e	49. 00
47.00	O TILL NON-KET WIDOKSABLE		— — —	11, 786, 320	<u> </u>		49.00
	N - DEPT 9101 RECLASS		U <sub>I</sub>	11, 700, 320			
1. 00	CASHI ERI NG/ACCOUNTS	5. 04	252, 081	21, 353	0		1.00
1.00	RECEI VABLE	3. 04	232, 001	21, 333	U		1.00
	RECEIVABLE	+					
	O UTILLITIES DECLASS		252, 081	21, 353			
4 00	0 - UTILITIES RECLASS	F 04		4/0 055			4 00
1.00	DATA PROCESSING	5. 01	0	163, 355	0	l l	1.00
2. 00	CASHI ERI NG/ACCOUNTS	5. 04	0	38, 053	0		2.00
	RECEI VABLE		_		_		
3.00	HOUSEKEEPI NG	9. 00	0	137, 901	0		3.00
4. 00	CARDI AC REHAB	69. 01	0	46, 556	0	l control of the cont	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	345, 225	0		5. 00
6.00	OTHER NON-REIMBURSABLE	1 <u>92.</u> 01	0_	7 <u>1, 5</u> 49			6. 00
	0		0	802, 639			
	P - C SECTION RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	40, 437	0	0		1.00
	TOTALS		40, 437	0			
500.00	Grand Total: Decreases		2, 600, 614	63, 785, 705			500.00
	·		·				

Provi der CCN: 15-0002

					Γο 12/31/2019		pared:
						6/25/2020 8: 0	3 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				.1		
1. 00	Land	5, 373, 674	0	(	0	0	1. 00
2.00	Land Improvements	6, 708, 539	136, 373	(	136, 373		2.00
3.00	Buildings and Fixtures	270, 530, 443	0	(	0	101, 744	3.00
4.00	Building Improvements	0	0	(	0	0	4.00
5.00	Fi xed Equi pment	0	0	(	0	0	5.00
6.00	Movable Equipment	203, 218, 657	8, 635, 406	(	8, 635, 406	0	6.00
7.00	HIT designated Assets	0	0	(	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	485, 831, 313	8, 771, 779	(	8, 771, 779	101, 744	8.00
9.00	Reconciling Items	0	0	(	0	0	9.00
10.00	Total (line 8 minus line 9)	485, 831, 313	8, 771, 779	(	8, 771, 779	101, 744	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	5, 373, 674	0				1.00
2.00	Land Improvements	6, 844, 912	0				2.00
3.00	Buildings and Fixtures	270, 428, 699	0				3.00
4.00	Building Improvements	o	0				4.00
5.00	Fi xed Equipment	o	0				5.00
6.00	Movable Equipment	211, 854, 063	0				6.00
7.00	HIT designated Assets	ol	0				7.00
8. 00	Subtotal (sum of lines 1-7)	494, 501, 348	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	494, 501, 348	0				10.00
	1.222. ( 2	, 55 . , 5 . 6	ŭ	I		'	

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	eu of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared:
			SU	JMMARY OF CAPI	TAL	1 67 237 2020 8. 0	JS alli
	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	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00
3. 00	Total (sum of lines 1-2)	0	0	(	0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
	· ·	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2019 Fo 12/31/2019		ared.
			'	10 12/31/2019	6/25/2020 8: 03	
	COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS O		2.00	0.00	1. 00	0.00	
1. 00 CAP REL COSTS-BLDG & FLXT	494, 501, 348	0	494, 501, 348	1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	494, 501, 348	0	494, 501, 348	1. 000000	0	3.00
	ALLOCAT	TION OF OTHER (	CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relat ed Costs				
	6. 00	7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS O		7.00	0.00	7.00	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	0	(	17, 956, 917	0	1.00
3.00 Total (sum of lines 1-2)	0	0	ď	17, 956, 917		3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12. 00	13.00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS O		12.00	13.00	14.00	15.00	
1. 00 CAP REL COSTS-BLDG & FLXT	1, 241, 622	0		0	19, 198, 539	1. 00
3.00 Total (sum of lines 1-2)	1, 241, 622			o o	19, 198, 539	3. 00

ADJUST	MENTS TO EXPENSES				Period: From 01/01/2019	Worksheet A-8	
					To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
			То	Expense Classification or			
				/From Which the Amount is	to be Adjusted		
	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	Investment income - CAP REL	В		P REL COSTS-BLDG & FLXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2)		0 **	* Cost Center Deleted ***	2. 00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		Ĭ	cost center bereted			
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		О		0. 00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		o		0. 00	0	5.00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
6.00	suppliers (chapter 8)		٩		0.00		0.00
7. 00	Tel ephone servi ces (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	
10. 00	Provi der-based physician adiustment	A-8-2	-10, 791, 528			0	10.00
11. 00	Sale of scrap, waste, etc.		O		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	o			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service				0. 00	0	13.00
14. 00	Cafeteria-employees and guests		-861, 149 CA	FETERI A	11. 00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		О		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		О		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-110, 736ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts		0		0.00	0	19. 00
19.00	Nursing and allied health education (tuition, fees,		٩		0.00		19.00
20.00	books, etc.) Vending machines	В	-21, 538 DI	FΤΛDV	10. 00	0	20.00
	Income from imposition of	b	0	LIMI	0. 00		21.00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		О		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0 RE	SPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	ОРН	YSI CAL THERAPY	66. 00		24.00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 **	* Cost Center Deleted ***	114. 00		25. 00
0.4.00	(chapter 21)		22 522	D DEL 20070 DIDO 4 FLVT			
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	Α	30, 530 CA	P REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL		0 **	* Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 **	* Cost Center Deleted ***			28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	CUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
50.00	therapy costs in excess of	V-0-9	UOC	OU ATTOMAL THERAPT	87.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OIAD	ULTS & PEDIATRICS	30. 00		30. 99
-0. //	instructions)			2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			-5. //

Heal th	Financial Systems		METHODIST HOS	PITALS. INC	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provi der CCN: 15-0002	Peri od:	Worksheet A-8	
						Date/Time Pre 6/25/2020 8:0	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	0.00	2.00	4.00	Ref.	
04.00		1. 00	2. 00	3.00	4.00	5. 00	04.00
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68. 00		31.00
32. 00	Depreciation and Interest		0		0.00	0	
33.00	DATA PROCESSING OTHER INCOME	В		DATA PROCESSING	5. 01	0	
33. 01	CASH, A/R, COLLECTIONS OTHER INCOME	В	· ·	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	0	33. 01
33. 02	A&G OTHER INCOME	В	-307, 039	OTHER A&G	5. 05	0	33. 02
34. 00	ENVIRONMENTAL SERVICES OTHER INCOME	В	-180	HOUSEKEEPI NG	9. 00	0	34.00
35.00	NURSING ADMIN OTHER INCOME	В	-2, 828	NURSING ADMINISTRATION	13. 00	0	35.00
36.00	PHARMACY	В	-62, 624	PHARMACY	15. 00	0	36.00
37. 00	PARAMED ED PROGRAM OTHER INCOME	В	-92, 472	PARAMED ED PROGRAM	23. 00	0	37.00
38.00	ADULTS & PEDS OTHER INCOME	В	-5, 148	ADULTS & PEDIATRICS	30.00	0	38.00
40.00	RADI OLOGY - THERAPUETI C	В	-9, 671	RADI OLOGY-THERAPEUTI C	55. 00	0	40.00
40.01	LAB OTHER INCOME	В	-65, 356	LABORATORY	60.00	0	40. 01
40. 02	BLOOD OTHER INCOME	В		WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	0	40. 02
40.03	CARDIAC REHAB OTHER INCOME	В	-119, 388	CARDI AC REHAB	69. 01	0	40.03
40. 04	ELECTROCEPHALOGRAPHY OTHER INCOME	В	-663	ELECTROENCEPHALOGRAPHY	70. 00	0	40. 04
40.05	CLINIC OTHER INCOME	В	-450	CLINIC	90.00	0	40. 05
40.06	EMERGENCY ROOM	В	-300	EMERGENCY	91. 00	0	40.06
40.07	EMT OFFSET	В	-43, 474	EMPLOYEE BENEFITS DEPARTMEN	Τ 4. 00	0	40. 07
40.08	EMT OFFSET	В	-192, 840	PARAMED ED PROGRAM	23. 00	0	40. 08
40.00	DUES (LODD) (LUS		00 040	OTUED AND	- 0-		1 40 00

-29, 240 OTHER A&G

-13, 299, 418

-331, 683 DRUGS CHARGED TO PATIENTS

1,898,272 EMPLOYEE BENEFITS DEPARTMENT

5.05

73.00

4.00

40.09

41.00

42.00

50.00

Α

Α

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

40.09

DUES/LOBBYI NG

42.00 PENSION ADJUSTMENT

41.00 RX PROGRAM

column 6, line 200.) (1) 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2
From 01/01/2019
To 12/31/2019 Date/Time Prepar Provider CCN: 15-0002

						To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physi ci an/Prov i der Component	
	1 00	2.00	2.00	4.00	F 00	/ 00	Hours	
1. 00	1.00	2. 00 CASHI ERI NG/ACCOUNTS	3. 00	4. 00 38, 006	5. 00	6.00	7.00	1. 00
1.00	3.04	RECEI VABLE	30,000	30,000	0	0	0	1.00
2.00	30 00	ADULTS & PEDIATRICS	9, 376, 086	9, 335, 646	40, 440	211, 500	275	2.00
3. 00		NEONATAL ICU	1, 010, 425		· ·	0		3.00
4.00		RADI OLOGY - ULTRASOUND	5, 670			0	o	4.00
5.00	57. 00	CT SCAN	8, 679	8, 679	0	0	o	5.00
6.00	91. 00	EMERGENCY	380, 625	380, 625	0	0	o	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0. 00		0	0	0	0	0	8.00
9.00	0. 00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10, 819, 491					200.00
	Wkst. A Line #	,	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
1. 00		CASHI ERI NG/ACCOUNTS	0.00			13.00		1.00
1.00	3.04	RECEI VABLE						1.00
2.00	30.00	ADULTS & PEDIATRICS	27, 963	1, 398	0	0	o	2.00
3.00		NEONATAL ICU	0	0	0	0	o	3.00
4.00		RADI OLOGY - ULTRASOUND	0	0	0	0	o	4.00
5.00	57. 00	CT SCAN	0	0	0	0	o	5.00
6.00		EMERGENCY	0	0	0	0	0	6.00
7.00	0. 00		0	0	0	0	0	7.00
8.00	0. 00		0	0	0	0	0	8.00
9. 00	0.00		0	0	0	0	1	9. 00
10.00	0.00		0	0	0	0		10.00
200.00			27, 963			0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		CASHI ERI NG/ACCOUNTS	0					1. 00
		RECEI VABLE						
2.00	30.00	ADULTS & PEDIATRICS	0	27, 963	12, 477	9, 348, 123		2.00
3.00	31. 01	NEONATAL ICU	0	0	0	1, 010, 425		3.00
4.00	54. 01	RADI OLOGY - ULTRASOUND	0	0	0	5, 670		4.00
5.00		CT SCAN	0	0	0	8, 679		5.00
6.00		EMERGENCY	0	0	0	380, 625		6.00
7. 00	0.00		0	0	0	0		7.00
8. 00	0.00		0	0	0	0		8. 00
9. 00	0.00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10.00
200. 00	I	I	1 0	27, 963	12, 477	10, 791, 528	l l	200. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002

					To	12/31/2019	Date/Time Pre 6/25/2020 8:0	
				CAPI TAL			0/23/2020 0.0	J alli
				RELATED COSTS				
		Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
			for Cost		BENEFI TS	PROCESSI NG	RECEIVING AND STORES	
			Allocation (from Wkst A		DEPARTMENT		STURES	
			col. 7)					
			0	1. 00	4. 00	5. 01	5. 02	
4 00		AL SERVICE COST CENTERS	10 100 500	40 400 500			ı	4 00
1. 00 4. 00		CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	19, 198, 539 31, 595, 401	19, 198, 539 80, 408				1.00 4.00
5. 01		DATA PROCESSING	10, 603, 417			11, 588, 567		5. 01
5. 02	1	PURCHASING RECEIVING AND STORES	3, 818, 330			0		5. 02
5.03		ADMITTING	2, 374, 698	132, 294	415, 166	0	4, 776	5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 720, 823			0	1, 689	5.04
5. 05 5. 06	1	OTHER A&G PATIENT TRANSPORTATION	20, 506, 040 599, 778		2, 324, 425 118, 381	11, 588, 567	5, 013 452	5. 05 5. 06
7. 00		OPERATION OF PLANT	17, 689, 620	1		0	53, 039	7.00
8. 00		LAUNDRY & LINEN SERVICE	1, 453, 279		0	0	39	8.00
9.00		HOUSEKEEPI NG	5, 554, 383		959, 601	0	41, 320	9. 00
10.00	1	DI ETARY	3, 532, 284			0	68, 498	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	1, 868, 193		331, 834	0	-	11.00
14.00	1	CENTRAL SERVICES & SUPPLY	3, 731, 317 1, 543, 510			0	2, 658 0	13. 00 14. 00
15. 00		PHARMACY	5, 651, 117			0	14, 383	
16.00	01600	MEDICAL RECORDS & LIBRARY	2, 704, 155	153, 941	423, 061	0	695	16. 00
17. 00	1	SOCIAL SERVICE	407, 414			0	0	17. 00
17. 01		STAFF EDUCATION	0	151, 763		0	0	17. 01
17. 02 21. 00	1	MEDICAL EDUCATION   I&R SERVICES-SALARY & FRINGES APPRVD	44, 617 222, 850	5, 092 0	0	0	120	17. 02 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	31, 168		0	0		22.00
23. 00		PARAMED ED PROGRAM	526, 664		158, 601	0		23. 00
		IENT ROUTINE SERVICE COST CENTERS	1					
30.00		ADULTS & PEDIATRICS	33, 816, 212		6, 812, 100	0		30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL ICU	7, 570, 845 1, 702, 035			0	88, 456 1, 301	31. 00 31. 01
40. 00		SUBPROVIDER - I PF	1, 307, 560			0	102	•
41.00		SUBPROVI DER - I RF	3, 015, 506			0	•	
43.00		NURSERY	1, 492, 126	332, 525	265, 002	0	16, 679	43.00
EO 00	ANCI L	LARY SERVICE COST CENTERS OPERATING ROOM	4 700 250	012 07/	0E1 001	0	122 020	50.00
50. 00 50. 01		ENDOSCOPY	6, 798, 358 2, 592, 236		851, 801 247, 791	0	132, 830 72, 542	
51.00	1	RECOVERY ROOM	1, 155, 977			0	3, 991	51.00
52.00		DELIVERY ROOM & LABOR ROOM	3, 264, 598		624, 556	0	13, 014	52.00
53.00		ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND	4, 000, 761	722, 382		0	16, 520 13, 897	
54. 01 55. 00	1	RADI OLOGY - OLTRASOUND	1, 706, 862 2, 023, 298			0	3, 235	
55. 01		INFUSION CENTER	10, 079		1, 742	0	83	
56.00		RADI OI SOTOPE	1, 904, 332			0		
57.00		CT SCAN	1, 961, 793			0	0.7070	
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 009, 193			0		1
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	3, 387, 683 9, 551, 220		452, 330 760, 320	0	55, 903 320, 236	1
60. 01		BLOOD LABORATORY	0, 331, 220	320, 171		0	0	60.00
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 407, 097	5, 242	246, 262	0	25, 403	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	3, 216, 359	0 105, 732	0 523, 042	0	0 62, 563	64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	1, 536, 609			0	746	1
67. 00		OCCUPATI ONAL THERAPY	1, 279, 839			0	757	•
68. 00		SPEECH PATHOLOGY	516, 912			0	1, 212	•
69.00		ELECTROCARDI OLOGY	817, 915			0	1, 584	•
69. 01 70. 00	1	CARDI AC REHAB ELECTROENCEPHALOGRAPHY	464, 787 1, 144, 906	0	88, 511 189, 457	0	261 0	69. 01 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 776, 424		109, 437	0	1, 273, 208	
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	10, 045, 657		Ö	Ö	1, 086, 096	
73.00	07300	DRUGS CHARGED TO PATIENTS	15, 539, 771		87, 202	0	50, 662	73.00
74. 00		RENAL DI ALYSI S	2, 074, 635	59, 673	35	0	2, 998	74.00
00 00		TIENT SERVICE COST CENTERS CLINIC	4, 515, 445	1 027 102	E27 477	0	7 010	00 00
90.00		EMERGENCY	10, 320, 870			0		
		OBSERVATION BEDS (NON-DISTINCT PART)	.5,520,670	330, 433	1, 555, 540	O	211,100	92.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2, 499, 905	0	456, 378	0	11, 122	101. 00

Health Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE CO	STS		Provi der CO		Period: From 01/01/2019	Worksheet B Part I	
					Γο 12/31/2019		pared:
			CAPI TAL			1 67 2 57 2 0 2 0 8 . 0	3 alli
			RELATED COSTS				
Cost Center Description		Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
		for Cost		BENEFITS	PROCESSI NG	RECEIVING AND	
		Allocation		DEPARTMENT		STORES	
		(from Wkst A					
		col. 7)					
		0	1.00	4. 00	5. 01	5. 02	
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES	1 through 117)	295, 805, 402	18, 640, 800	26, 909, 64	11, 588, 567	4, 073, 771	118. 00
NONREI MBURSABLE COST CENTERS				•			
190.00 19000 GIFT, FLOWER, COFFEE SHO	P & CANTEEN	11	24, 520	(	0	ł	190. 00
191. 00 19100 RESEARCH		0	0	(	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI	CES	34, 651, 152			5 0	32, 272	
192. 01 19201 OTHER NON-REI MBURSABLE		641, 955			0	l e	192. 01
192. 02 19202 FAMILY HEALTH/GARY COMM	HEALTH	214, 336	122, 491	35, 870	0		192. 02
193. 00 19300 NONPALD WORKERS		0	0	(	0		193. 00
200.00 Cross Foot Adjustments						l	200. 00
201.00 Negative Cost Centers			0	(	0	l e	201. 00
202.00 TOTAL (sum lines 118 thr	ough 201)	331, 312, 856	19, 198, 539	31, 675, 809	9 11, 588, 567	4, 106, 092	202. 00

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

				12/31/2019	6/25/2020 8:0	
Cost Center Description	ADMITTI NG	CASHI ERI NG/AC COUNTS	Subtotal	OTHER A&G	PATI ENT TRANSPORTATI 0	
		RECEI VABLE			N N	
	5. 03	5. 04	5A. 04	5. 05	5. 06	
GENERAL SERVICE COST CENTERS  1. 00   OO100   CAP REL COSTS-BLDG & FLXT					I	1 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 01   00550 DATA   PROCESSING						5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03   00570   ADMI TTI NG	2, 926, 934					5. 03
5. 04   00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	7, 618, 197	05 770 700	05 770 700		5.04
5. 05   00590 OTHER A&G 5. 06   00592 PATIENT TRANSPORTATION	0	0	35, 779, 783 718, 611	35, 779, 783 87, 002		5. 05 5. 06
7. 00   00700   0PERATION OF PLANT	0	- 1	22, 639, 954	2, 740, 997	0 005,013	7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	0	Ö	1, 696, 000	205, 333		8.00
9. 00   00900   HOUSEKEEPI NG	0	0	6, 836, 243	827, 657	0	9. 00
10. 00   01000   DI ETARY	0	0	4, 298, 560	520, 422	0	10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0	0 0	2, 379, 541 4, 513, 549	288, 089 546, 451	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	2, 164, 826	262, 093		14.00
15. 00 01500 PHARMACY	0		5, 923, 594	717, 164	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	3, 281, 852	397, 331	0	16.00
17. 00   01700   SOCI AL   SERVI CE	0		517, 224	62, 620		17.00
17. 01   01701   STAFF EDUCATION 17. 02   01702   MEDICAL EDUCATION	0	0 0	151, 763 49, 829	18, 374 6, 033	0	17. 01 17. 02
21.00   02100   L&R SERVICES-SALARY & FRINGES APPRVD	0		222, 850	26, 980		21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	Ö	Ö	91, 985	11, 137		22. 00
23. 00 02300 PARAMED ED PROGRAM	0	0	731, 804	88, 599	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.47.577		44 000 004		045 477	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	247, 577 39, 998		46, 023, 031 9, 355, 683	5, 571, 848 1, 132, 683		30. 00 31. 00
31. 01   03101   NEONATAL   CU	11, 360		2, 110, 586	255, 527	18	31.00
40. 00   04000   SUBPROVI DER -   PF	11, 484	29, 886	1, 663, 086	201, 348		40.00
41. 00   04100   SUBPROVI DER - I RF	16, 634		4, 083, 370	494, 370		41.00
43. 00 04300 NURSERY	5, 266	13, 705	2, 125, 303	257, 308	0	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	330, 770	860, 832	9, 786, 667	1, 184, 862	55	50.00
50. 00   05000   0FERATTING   ROOM   50. 01   05001   ENDOSCOPY	43, 624		3, 069, 724	371, 648		50.00
51. 00   05100   RECOVERY ROOM	23, 300		1, 665, 518	201, 643		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 165	26, 454	4, 034, 131	488, 408	7, 570	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   RADI OLOGY - ULTRASOUND	94, 992		5, 592, 989 2, 204, 135	677, 138 266, 852		54. 00 54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	42, 718 48, 192		2, 484, 199	300, 759		55.00
55. 01   05501   NFUSI ON CENTER	537	1, 398	18, 740	2, 269		55. 01
56. 00   05600   RADI OI SOTOPE	36, 097	93, 942	2, 384, 109	288, 642	44, 013	56.00
57. 00   05700   CT   SCAN	290, 986		3, 385, 977	409, 937		57.00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	70, 748 159, 647		1, 417, 731	171, 643		58. 00 59. 00
60. 00   06000   LABORATORY	360, 901	415, 483 940, 071	4, 580, 413 12, 252, 939	554, 546 1, 483, 451	25, 417	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0		60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 158	60, 269	1, 767, 431	213, 981	0	62.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	104, 883	272, 958	4, 285, 537	518, 846		65.00
66. 00   06600   PHYSI CAL THERAPY	18, 229		2, 066, 815	250, 227	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 850	36, 046	1, 728, 581	209, 278	0	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 046		664, 775	80, 484		68.00
69. 00   06900  ELECTROCARDI OLOGY 69. 01   06901  CARDI AC REHAB	59, 399		1, 188, 253	143, 861	3, 072	69. 00 69. 01
69. 01   06901   CARDI AC REHAB 70. 00   07000   ELECTROENCEPHALOGRAPHY	2, 088 60, 543		561, 081 1, 552, 470	67, 930 187, 956		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 960		13, 470, 980	1, 630, 918		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	62, 824	163, 501	11, 358, 078	1, 375, 111	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	356, 653		16, 985, 109	2, 056, 370		73. 00
74. 00 O7400 RENAL DIALYSIS	20, 047	52, 173	2, 209, 561	267, 509	55	74.00
90. 00 09000 CLINIC	59, 630	155, 188	6, 312, 741	764, 277	311	90.00
91. 00   09100   EMERGENCY	169, 452		13, 064, 606	1, 581, 719		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 752	111, 501	0	., 551, 717	3,571	92.00
OTHER REIMBURSABLE COST CENTERS			~ [			
101.00 10100 HOME HEALTH AGENCY	8, 176	21, 279	2, 996, 860	362, 827	0	101. 00
SPECIAL PURPOSE COST CENTERS	2.024.001	7 /40 407	200 440 477	20 022 452	005 (60	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 926, 934	7, 618, 197	290, 449, 177	30, 832, 458	805, 613	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	24, 531	2, 970	0	190. 00
191. 00 19100 RESEARCH	o o		0	0		191. 00

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002
From 01/01/2019
To 12/31/2019
Date/Time Prepared:

						6/25/2020 8:0	3 am
	Cost Center Description	ADMITTI NG	CASHI ERI NG/AC	Subtotal	OTHER A&G	PATI ENT	
			COUNTS			TRANSPORTATIO	
			RECEI VABLE			N	
		5. 03	5. 04	5A. 04	5. 05	5. 06	
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	39, 777, 381	4, 815, 808	0	192.00
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	689, 024	83, 419	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	372, 743	45, 128	0	192. 02
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers	0	o	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 926, 934	7, 618, 197	331, 312, 856	35, 779, 783	805, 613	202.00

Provider CCN: 15-0002

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: 6/25/2020 8:03 am

						6/25/2020 8: 0	3 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	OO570 ADMI TTI NG						5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5.05	00590 OTHER A&G						5. 05
5. 06	00592 PATIENT TRANSPORTATION						5. 06
7. 00	00700 OPERATION OF PLANT	25, 380, 951					
			0 070 047				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	477, 013					8. 00
9.00	00900 HOUSEKEEPI NG	552, 211	0	8, 216, 111			9. 00
10.00	01000 DI ETARY	504, 390	0	170, 178	5, 493, 550		10.00
11.00	01100 CAFETERI A	352, 628	0	118, 974	o	3, 139, 232	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	169, 932	n	57, 334	o	80, 770	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	959, 191	4, 051		Ö	40, 654	14.00
					-		
15. 00	01500 PHARMACY	507, 306			0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	302, 586	0	102, 090	0	101, 146	16.00
17.00	01700 SOCI AL SERVI CE	43, 594	0	14, 708	0	16, 867	17.00
17.01	01701 STAFF EDUCATION	298, 304	0	100, 646	ol	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	10, 009	Ö		ol	0	17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	10,007	0	1 1	ő	0	21.00
			_	· ·		-	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	119, 541	0	,	0	0	22. 00
23. 00	02300 PARAMED ED PROGRAM	90, 024	0	30, 373	0	35, 683	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 381, 967	1, 009, 257	2, 828, 022	4, 338, 878	1, 082, 268	30.00
31. 00	03100   NTENSI VE CARE UNI T	531, 579			211, 570	173, 175	31. 00
				1			
31. 01	03101 NEONATAL I CU	60, 426			0	43, 183	31. 01
40.00	04000 SUBPROVI DER - I PF	106, 294	0		147, 517	37, 881	40. 00
41.00	04100 SUBPROVI DER - I RF	836, 091	163, 156	282, 092	481, 959	94, 525	41.00
43.00	04300 NURSERY	653, 608	34, 192	220, 523	ol	34, 727	43.00
	ANCILLARY SERVICE COST CENTERS				-,		
50.00	05000 OPERATING ROOM	1, 596, 208	254, 223	538, 550	ol	147, 385	50.00
	1 1				-		
50. 01	05001 ENDOSCOPY	0	45, 163	1 1	0	38, 178	50. 01
51.00	05100 RECOVERY ROOM	389, 264	15, 770	1	0	28, 154	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	187, 407	34, 544	63, 230	139, 642	94, 830	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 419, 907	63, 622	479, 067	ol	98, 566	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	135, 250	17, 674		ol	39, 073	54. 01
					ol		
55.00	05500 RADI OLOGY-THERAPEUTI C	360, 871	13, 696		-	15, 169	55.00
55. 01	05501 I NFUSI ON CENTER	9, 634	0	3, 250	0	293	55. 01
56.00	05600  RADI 01 S0T0PE	241, 999	15, 688	81, 649	0	14, 593	56.00
57.00	05700 CT SCAN	229, 154	21, 586	77, 315	0	40, 706	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	112, 530			ol	15, 062	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	214, 970			ol	60, 149	59. 00
60.00						138, 024	
	06000 LABORATORY	629, 363	0		0	·	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 303	0	3, 476	0	73, 114	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1 1	ol	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	٥	0	o	ol	0	64.00
		207 025	0	1	9	-	
65.00	06500 RESPIRATORY THERAPY	207, 825		70, 119	٥	89, 565	65.00
66. 00	06600 PHYSI CAL THERAPY	328, 356			0	41, 116	
67.00	06700 OCCUPATI ONAL THERAPY	282, 194	4, 085	95, 210	0	35, 833	67.00
68.00	06800 SPEECH PATHOLOGY	48, 063	0	16, 216	0	12, 445	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	3, 552		ol	27, 537	69. 00
69. 01	06901 CARDI AC REHAB	l o	0,002	0	o l	14, 802	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	4 000		o o		
70.00	1 1	0	6, 888		٥	28, 738	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	이	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	44, 477	0	15, 006	ol	12, 364	73. 00
	07400 RENAL DIALYSIS	117, 293	31, 135	1	ol	0	74.00
74.00		117, 275	31, 133	37, 374	<u> </u>	0	74.00
00.00	OUTPATIENT SERVICE COST CENTERS	2 222 472	00.405	(07.005		70 470	00.00
	09000 CLI NI C	2, 038, 672		1	0	79, 170	
91.00	09100 EMERGENCY	724, 230	314, 617	244, 351	173, 984	253, 487	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	Λ	101. 00
	SPECIAL PURPOSE COST CENTERS			. 0	<u> </u>	0	
110 00		24 204 ((4	2 270 244	7 04/ 222	E 400 EE0	2 120 222	110 00
118.00	<u> </u>	24, 284, 664	2, 378, 346	7, 846, 232	5, 493, 550	3, 139, 232	I 18. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	48, 196	0	16, 261	0	0	190. 00
	19100 RESEARCH	0	0		o	0	191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	714, 811	Ö	1	ol		192.00
. , 50	1 11 11 11 11 11 11 11 11 11 11 11 11 1	, , , , , , , , ,	·		<u> </u>	٥	50

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	Peri od:

					6/25/2020 8:0	3 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
192. 01 19201 OTHER NON-REI MBURSABLE	92, 512	0	31, 213	0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	240, 768	0	81, 233	0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
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)	25, 380, 951	2, 378, 346	8, 216, 111	5, 493, 550	3, 139, 232	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002

| Peri od: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared:

					Ic	) 12/31/2019	Date/lime Pre   6/25/2020 8:0	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
			ADMI NI STRATI O	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
			13. 00	14. 00	15. 00	16. 00	17. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING						4. 00 5. 01
5. 01	1	PURCHASING RECEIVING AND STORES						5. 01
5. 03	1	ADMITTING						5.03
5.04	00580	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05		OTHER A&G						5. 05
5.06		PATIENT TRANSPORTATION						5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00		HOUSEKEEPI NG						9. 00
10.00	1	DI ETARY						10. 00
11. 00	1	CAFETERI A						11. 00
13.00	1	NURSI NG ADMI NI STRATI ON	5, 368, 036	0.754.450				13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	3, 754, 458 0				14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	0		4, 185, 005		16.00
17. 00	1	SOCIAL SERVICE	43, 522	0	Ö	0	698, 535	17. 00
17. 01	1	STAFF EDUCATION	0	0	0	О	0	17. 01
17. 02	1	MEDICAL EDUCATION	0	0	0	0	0	17. 02
21.00	1	I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PROGRAM	92, 076	0		0	0	22. 00 23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS	72,070		η Ο	<u> </u>		23.00
30.00		ADULTS & PEDIATRICS	2, 792, 641	0	0	353, 912	557, 830	30.00
31. 00	1	INTENSIVE CARE UNIT	446, 855	0	1	57, 177	0	31.00
31. 01	1	NEONATAL I CU	111, 428	0	1	16, 239	0	31.01
40. 00 41. 00	1	SUBPROVI DER - I PF SUBPROVI DER - I RF	97, 747 243, 908	0	1	16, 416 23, 778	111 744	40. 00 41. 00
43.00		NURSERY	89, 607	0		7, 528	111, 766 0	43.00
10.00		LARY SERVICE COST CENTERS	07,007		,	7,020		10.00
50.00	05000	OPERATING ROOM	380, 306	0	0	472, 835	0	50.00
50. 01		ENDOSCOPY	98, 513	0		62, 360	0	50. 01
51.00	1	RECOVERY ROOM	72, 647	0	0	33, 307	0	51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	244, 696	0		14, 531	0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	o	0		135, 791	0	54.00
54. 01	1	RADI OLOGY - ULTRASOUND	0	0	0	61, 065	0	54. 01
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	68, 891	0	55.00
55. 01		I NFUSI ON CENTER	0	0	0	768	0	55. 01
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	0		51, 600 415, 964	0	56. 00 57. 00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0		101, 134	0	58.00
59. 00		CARDI AC CATHETERI ZATI ON	o	0		228, 215	0	59.00
60.00	06000	LABORATORY	0	0	589, 366	516, 863	0	60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	00.0.
	1	PBP CLINICAL LAB SERVICES-PRGM ONLY				22 424		61.00
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.		0		33, 104 0	0	62. 00 63. 00
64. 00		INTRAVENOUS THERAPY		0		o	0	64.00
65. 00		RESPI RATORY THERAPY	O	0	Ö	149, 930	0	65.00
66.00		PHYSI CAL THERAPY	0	0	0	26, 059	0	66. 00
67.00		OCCUPATIONAL THERAPY	0	0	0	19, 799	0	67.00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		8, 642 84, 911	0	68. 00 69. 00
69. 00		CARDI AC REHAB	0	0		2, 985	0	69.00
70. 00		ELECTROENCEPHALOGRAPHY	o	0	o o	86, 546	0	70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 026, 113	o	167, 194	0	71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	1, 728, 345		89, 807	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	0		509, 835	0	73.00
74. 00		RENAL DIALYSIS TIENT SERVICE COST CENTERS	0	0	0	28, 658	0	74. 00
90. 00		CLINIC	ol	0	0	85, 241	0	90.00
	1	EMERGENCY	654, 090	0		242, 232	28, 939	
		OBSERVATION BEDS (NON-DISTINCT PART)				. ,		92.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	0	0	13, 872	11, 688	0	101. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	5, 368, 036	3, 754, 458	7, 213, 857	4, 185, 005	698, 535	118 00
110.00		IMBURSABLE COST CENTERS	5, 300, 030	3, 734, 438	η /, ΖΙ3, 05/	4, 160, 005	090, 035	1110.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100	RESEARCH	o	0	0	o	0	191. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	From 01/01/2019	Worksheet B Part I Date/Time Prepared:	

					6/25/2020 8:0	3 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16. 00	17. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0	105, 369	0	0	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
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)	5, 368, 036	3, 754, 458	7, 319, 226	4, 185, 005	698, 535	202. 00
		'	•			•

Provider CCN: 15-0002

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

CONTROL OF CONTROL   CONTROL OF						6/25/2020 8:0	3 am
BENDEATION   BENDEATION   STR STRINGES   PROPRIOR   PROSESS   PROPRIOR				INTERNS &	RESI DENTS		
BIDUATION	Occident Description	CTAFF	MEDICAL	CEDVI OEC CALA	CEDVI OFC. OTHE	DADAMED ED	
CARRIAN   SQUART   COST CAUSES   TOTAL   TOT	Cost Center Description						
Chernell Service DOS CENTERS							
1.00   007000   CARP   FELL COSTS-SELLO & FIXT	GENERAL SERVICE COST CENTERS	17.01	17.02	21.00	22.00	25.00	
4 00 00000 PRINT PROFESTING PRANTENTS 5 01 000000 PRINT PROFESTING MAIN STORTS 5 02 000000 PRINT PROFESTING MAIN STORTS 5 03 000000 PRINT PROFESTING MAIN STORTS 5 04 0000000 PRINT PROFESTING MAIN STORTS 5 05 0000000 PRINT PROFESTING MAIN STORTS 6 05 0000000 PRINT							1.00
5.02   ODS-60 PRINCHASTING SECELY MIS AND STORES   5.02   5.03   5.04   5.00   5.07   5.00   5.07   5.00						  -	4.00
5.03   0.0070   ADMITTING							
5.04   5.05	5. 02 00560 PURCHASING RECEIVING AND STORES					  -	5. 02
5.05 00 00000 OPHER AND OF PLANE  1.00 00000 OPHERATION OF PLANE  1.00 00000 OPHERATION OF PLANE  1.00 00000 OPHERATION OF PLANE  1.00 00 00000 OPHERATION OF PLANE  1.00 01000 OPHERATION OPHERATION  1.00 01000 OPHERATION OPHERATION OPHERATION  1.00 01000 OPHERATION OPHERATION  1.00 01000 OPHERATION OPHERATION OPHERATION  1.00 01000 OPHERATION	5. 03   00570   ADMITTING					  -	5. 03
5.00	5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					  -	5.04
7.00   00700    00700    00FERTION OF PLANT							5. 05
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000							
9.00   009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  00900  00900  00900  00900  00900  00900  00900  00900  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  009000  0090000  0090000  0090000  00900000000						  -	
10.00   01000   EFTARY						  -	
11.00 01300 (CAFETRIA)						  -	
13.00   1300   MIRSS NO. AMM IN STRATION     14.00   1400   CONTROL SERVICES & SUPPLY     14.00   1400   CONTROL SERVICES & SUPPLY     15.00						  -	
14.00   01400   CENTRAL SERVICES & SUPPLY						  -	
15.00   1500   PHASMACY						  -	
10.00   1000   MEDICAL RECORDS & LIBRARY     10.00   17.00						  -	
17.00   1700   SOCIAL SERVICE     17.00   1701						  -	
17.01   01701   STAFF EDUCATION   569,087   17.02   1702   1801   249,830   229,830   17.02   170.02   1702   170.02   1702   1702   170.02   1702   170.0						  -	
17. 02   1702   MEDICAL EDUCATION   0   69,248   21,00   220   0   220   0   249,830   262,995   22.00   220   0   220   0   18, SERVICES-OTHER PROX COSTS APPRVD   0   0   0   249,830   262,995   1,069,309   22.00   23.00   2300   2300   249,830   262,995   1,069,309   20.00		560 087				<u> </u>	
21.00   02100   RR SERVICES - SALARY & FRINGES APPRUD   0   0   249,830   262,995   1,069,307   22.00   220   02300   PARAMED ED PROGRAM   7500   0   0   0   262,995   1,069,307   22.00   23			69 248			  -	
22.00   02200   RAY SERVICES -OTHER PROM COSTS APPRVD   0   0   262,995   1,069,309   23.00   2300   02300   PARAMED ED PROMORAM   750   0   0   0   0   0   0   0   0   0		- 1		249 830		  -	
23.00		- 1	-	247,030			
INPATI ENT ROUTI NE SERVICE COST CENTERS   259, 302					202, 770	1 069 309	
30.00		, 55				170077007	20.00
31.00		259, 302	0	0	0	0	30.00
40. 00   04000   SUPPROVI DER - I PF	31.00 03100 INTENSIVE CARE UNIT		0	0	o	0	31.00
41.00   04100   SUBPROVI DER - I RF   24, 600   0   0   0   0   41.00	31. 01   03101   NEONATAL   CU	4, 181	0	0	o	0	31.01
43. 00   04300   NURSERY   12,780   0   0   0   0   0   43. 00	40. 00   04000   SUBPROVI DER - I PF		0	0	О	0	
ANCIL LARY SERVICE COST CENTERS	41. 00   04100   SUBPROVI DER - I RF	24, 600	0	0	o	0	41.00
50.00   05000   05000   05000   05000   0		12, 780	0	0	0	0	43.00
50. 01   OSDO1   ENDOSCOPY	ANCILLARY SERVICE COST CENTERS						
11							
S2.00   05200   DELIVERY ROOM & LABOR ROOM   25.086   0   0   0   0   0   0   0   0   0			-				
53.00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   53.00			-				
54.00   05400   RADI OLOGY-DI AGNOSTIC   9,808   0   0   0   0   54.01			-	_	-	-	
54.01   05401   RADIOLOGY - ULTRASQUIND		-	-				
55. 00   05500   ABJOLOGY-THERAPEUTIC			-	_	0		
55. 01   05501   INFUSION CENTER			-		0		
56.00   05600   ABDI OLISOTOPE   42			-	0	0		
57.00   05700   05700   05700   05700   058000   058000   058000   058000   058000   058000   058000   058000   0580			-	0	0	-	
58.00   05900   CARDIAC CATHETERI ZATION   20,662   0   0   0   0   0   58.00			-		_		
59.00   05900   CARDIAC CATHETERIZATION   20,662   0   0   0   0   59,00			-			-	
60. 00   06000   LABORATORY   860   0   0   0   0   0   60. 00   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   607   0   0   0   0   0   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   11, 661   0   0   0   0   0   66. 00   06500   RESPI RATORY THERAPY   470   0   0   0   0   0   67. 00   06700   OCCUPATIONAL THERAPY   486   0   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   433   0   0   0   0   0   69. 01   06901   CARDIAC REHAB   0   0   0   0   0   69. 01   06901   CARDIAC REHAB   0   0   0   0   0   69. 01   06901   CARDIAC REHAB   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   723   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   723   0   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   90   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   90   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   90   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   90   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES   70   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   90   0   0   0   0   72. 00   07200   ONLOR CHARGED TO PATIENTS   90   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   75. 00   07400   RENAL DIALYSIS   0   0   0   0   0   76. 00   07400   RENAL DIALYSIS   0   0   0   0   0   77. 00   07400   RENAL DIALYSIS   0   0   0   0   78. 00   07400   RENAL DIALYSIS   0   0   0   0   0   79. 00   07400   RENAL DIALYSIS   0   0   0   0   0   70. 00   07400   RENAL DIALYSIS   0   0   0   0   70. 00   07400   RENAL DIALYSIS   0   0   0   0		l l	-				
60. 01   0601   BLOOD LABORATORY   0   0   0   0   0   0   60. 01   61. 00   06100   PBP CLI NICAL LAB SERVICES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   607   0   0   0   0   0   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   11, 661   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   470   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   486   0   0   0   0   0   68. 00   06800   SPECT PATHOLOGY   433   0   0   0   0   0   69. 01   06901   CARDIA CE REHAB   0   0   0   0   0   69. 01   06901   CARDIA CE REHAB   0   0   0   0   0   71. 00   07000   ELECTROCARDI OLOGY   676   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   71. 00   07300   RENAL DI ALYSIS   0   0   0   0   0   71. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   71. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   71. 00   07400   DEBERGENCY   58, 407   69, 248   249, 830   262, 995   1, 069, 309   71. 00   09200   DESERVATION BEDS (NON-DISTINCT PART)   11, 624   0   0   0   0   71. 00   ONDONE   MEDITALS (SUM OF LINES 1 through 117)   558, 139   69, 248   249, 830   262, 995   1, 069, 309   118. 00   718. 00   SPECI AL PURPOSE COST CENTERS			-			-	
61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   607   0   0   0   0   0   0   62. 00   0300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   0   0   0		_1	0	0	0		
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   607   0   0   0   0   0   62. 00   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   64. 00   06400   INTRAVENUUS THERAPY   0   0   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   11, 661   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   470   0   0   0   0   0   67. 00   06700   0620PATIONAL THERAPY   486   0   0   0   0   0   68. 00   06600   SPECH PATHOLOGY   433   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   676   0   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   676   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   RENAL DI ALYSI S   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   75. 00   09000   CLINI C   COST CENTERS    101. 00   O9000   OBSERVATI ON BEDS (NON-DI STINCT PART)   0   75. 00   O9100   MORE MERGENCY   11, 624   0   0   0   0   75. 00   OSUBRISH MBURSABLE COST CENTERS   101. 00   SUBTORLES (SUM OF LINES 117)   11, 624   0   0   0   75. 00   SONORE MBURSABLE COST CENTERS   101. 00   SUBTORLES (SUM OF LINES 117)   1558, 139   69, 248   249, 830   262, 995   1, 069, 309   118. 00   100. 00   SONORE MBURSABLE COST CENTERS   0   0   0   0    100. 00   SONORE MBURSABLE COST CENTERS   0   0   0   0    100. 00   SUBTORLES (SUM OF LINES 1 through 117)   558, 139   69, 248   249, 830   262, 995   1, 069, 309   118. 00    100. 00   SONORE MBURSABLE COST CENTERS   0   0   0   0    100. 00   SONORE MBURSABLE COST CENTERS   0   0   0   0    100. 00   00   00   00   00   00   00		o <sub>l</sub>	O	0	ď	0	
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   63. 00   64. 00   06400   INTRAVENDUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   11,661   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   470   0   0   0   0   0   65. 00   67. 00   06700   OCCUPATI ONAL THERAPY   486   0   0   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   433   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   676   0   0   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   0   70. 00   07000   ELECTROCEPHALOGRAPHY   723   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   723   0   0   0   0   0   71. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   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   90   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   75. 00   07400   RENAL DI ALYSI S   0   0   0   0   76. 00   09000   CLINIC   1,827   0   0   0   0   79. 00   09000   CLINIC   58,407   69,248   249,830   262,995   1,069,309   79. 00   09100   EMERGENCY   11,624   0   0   0   0   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   718. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   719. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309   719. 00   SUBTOTALS (SUM) OF LINES 1 through 117)   558,139   69,248   249,830   262,995   1,069,309		607	0	0	0	0	
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   11, 661   0   0   0   0   0   65. 00   66. 00   06600   PHSPI CAL THERAPY   470   0   0   0   0   0   65. 00   67. 00   06700   OCCUPATI ONAL THERAPY   486   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   433   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   676   0   0   0   0   0   69. 00   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   723   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   90   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   75. 00   09000   CLI NI C   090000   CLI NI C   09000   CLI NI C   09000   CLI NI C   09000   CLI NI C   09000   CLI N		l l	0	0	o		
65. 00   06500   RESPIRATORY THERAPY   11, 661   0   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   470   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   486   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   433   0   0   0   0   0   68. 00   69. 00   06900   CELECTROCARDI OLOGY   676   0   0   0   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   723   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   90   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   75. 00   09000   CLI NI C   0   18,827   0   0   0   0   76. 00   09000   CLI NI C   0   0   77. 00   09000   MERGENCY   58,407   69,248   249,830   262,995   1,069,309   78. 00   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   79. 00   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   79. 00   SPECLA PURPOSE COST CENTERS   0   0   0   0   0   70. 00   NORE   MBURSABLE COST CENTERS   0   0   0   0   70. 00   NORE   MBURSABLE COST CENTERS   0   0   0   0   70. 00   0   0   0   0   70. 00   0   0   0   0   0   70. 00   0   0   0   0   0   70. 00   0   0   0   0   70. 00   0   0   0   0   70. 00   0   0   0   70. 00   0   0   0   0   70. 00   0   0   0   0   70. 00   0   0   0   7		o	0	Ö	o		
66. 00 06600 PHYSICAL THERAPY 470 0 0 0 0 0 0 66. 00 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 486 0 0 0 0 0 0 67. 00 68. 00 68. 00 06800 SPEECH PATHOLOGY 433 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		11, 661	0	0	o		
67. 00			0	0	o	0	
68. 00			0	0	o		
69. 01   06901   CARDI AC REHAB   0   0   0   0   0   0   69. 01			0	0	o	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 723 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 90 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 73. 00 74. 00 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 1, 827 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 58, 407 69, 248 249, 830 262, 995 1, 069, 309 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 0THER REI MBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 11, 624 0 0 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 558, 139 69, 248 249, 830 262, 995 1, 069, 309 118. 00	69. 00   06900   ELECTROCARDI OLOGY	676	0	0	0	0	69. 00
71. 00			0	0	0	0	
72. 00			0	0	0		
73. 00		- 1	0	0	0		
74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 74. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0		
OUTPATIENT SERVICE COST CENTERS   OUTP		l l	0	0	0		
90. 00		0	0	0	0	0	74.00
91. 00		a 00-l	_1	-		-	00.00
92. 00			0		0 000		
OTHER REIMBURSABLE COST CENTERS  101.00		58, 407	69, 248	249, 830	262, 995	1, 069, 309	
101. 00							92.00
SPECIAL PURPOSE COST CENTERS		11 424	0			^	101 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 558, 139 69, 248 249, 830 262, 995 1, 069, 309 118. 00 NONREI MBURSABLE COST CENTERS		11,624	Ü	0	ا	0	1101.00
NONREI MBURSABLE COST CENTERS		558 130	69 249	240 830	262 005	1 060 300	118 00
		330, 139	07, 240	247,030	202, 770	1,007,309	1. 10. 00
		0	0	0	O	0	190. 00
		1			1		

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002
From 01/01/2019
To 12/31/2019
Date/Time Prepared:
6/25/2020 8:03 am

					6/25/2020 8:0	<u>3 am </u>
			INTERNS &	RESI DENTS		
Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	17. 01	17. 02	21. 00	22. 00	23. 00	
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10, 906	0	0	0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	42	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	569, 087	69, 248	249, 830	262, 995	1, 069, 309	202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002

Content   Service   Content   Cont						Т	o 12/31/2019 Date/Time Pro 6/25/2020 8:0	
COST & PORT   STUDY COST CENTERS   24, 00   23, 00   20, 00   1   1, 00   10   1, 00   10   1, 00			Cost Center Description	Subtotal		Total	, 6, 23, 2323 3.	
Stephane								
COLORD   SERVICE DOST CENTERS   1.00   25.00   26.00								
CREATE SERVICE COST CENTERS				0.4.00		04.00		
1.00   DOTION CAN PELL CORSTS-BLUE & FIRX		GENER	PAL SERVICE COST CENTERS	24. 00	25. 00	26.00		
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	1.00							1.00
Description								1
0.0074   DAWN TTINK		1	1					
5.04   0.0080  CASHI EN INFACCIONITS RECEIVABLE								1
0.000   0.000   CAURDERY & LINEN SERVICE   0.000   0.000   CAURDERY & LINEN SERVICE   0.0000   0.000   0.000   0.0000   0.000   0.0000   0.0								
2.00   0.000   DOPERATION OF PLANT								
8 00 00 00000 LAURDRY & LINEN SERVICE 9 9.00 00000 INDISERCE PINES 9.00 00000 INDISERCE PINES 9.00 10.00 0 INDISERCE PINES 9.00 0 INDISERCE PINES 9.00 10.00 0 INDISERCE PINES 9.00 0 INDISERC		1	ł ·					1
9.00   00900  MUSEKEEPING   9.00   11.00   01100  CAFELRIA   11.00   1		1	1					1
11.00   10100   CAFETERIA								1
13.00   1300   NIRSING ADMINI STRATION     14.00   1400   01400   01500   PHARMACY     15.00		1	1					
14.00   01400  CENTRAL SERVICES & SUPPLY     14.00     15.00     16.00   1600  DEPLICAL RECORDS & LIBRARY		1						•
15.00 0 1500 [PHARMACY   15.00   17.00		1						
17.00   1700   SOCIAL SERVICE								•
17. 01   17.00   1702   METCAL EDUCATION     17. 01   17. 01   17. 02   1702								
17. 02   O702   MEDICAL EDUCATION								•
21.00								
23.00		1						
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30								•
30.00	23. 00	-	1					23. 00
31.00   03100   INTERSIVE CARE UNIT   12, 306, 663   0   12, 306, 663   31.00   10   3010   10   3010   10   6004TAL ICU   2, 621, 975   0   2, 621, 975   31.01   40.00   4000   5UBRROVIDER - IPF   2, 310, 655   0   2, 310, 655   40.00   40.00   40.00   40.00   5UBRROVIDER - IPF   6, 846, 801   0   6, 846, 801   41.00   40	30 00			73 514 433	O	73 514 433		30.00
40. 00   04000   SUBPROVI DER - I PF   2, 310, 655   0 2, 310, 655   40. 00								
11 00   04100   SUBPROVI DER - 1 IRF   6, 846, 801   0   6, 846, 801   41, 00   A30,								
43. 00   04300   NURSERY   3, 435, 576   0   3, 435, 576     43. 00		1	1		-			
ANCILLARY SERVICE COST CENTERS   50.00   50.		1	1					1
50.01   GS001   ENDSCOPY   3,714,577   0 3,714,577   50.01	10.00			0, 100, 0, 0	٩	07 1007 070		
51.00   05100   RECOVERY ROOM   2.541, 988   0   2.541, 988   51.00		1			_			1
52.00   05200   DELI VIERY ROOM & LABOR ROOM   5,334,075   0   5,334,075   0   53.00   05300   085300   NESTRIESI LOLGY   0   0   0   0   0   0   0   0   0								•
53.00   05300   ANESTHESI OLOGY   0   0   53.00   0   54.00   55.00								•
54. 01   05401   RADIOLOGY - ULTRASQUND   2, 855, 724   0   2, 855, 724   54. 01				0	_			
55. 00         05500 RADI OLOGY-THERAPEUTI C         3, 371, 913         0         3, 371, 913         55. 00           55. 01         05501 INFUSION CENTER         34, 954         0         34, 954         55. 01           56. 00         05600 RADI OLOGY-THERAPEUTIC         34, 954         0         34, 954         55. 01           57. 00         05700 CT SCAN         4, 734, 529         0         4, 734, 529         57. 00           58. 00         05800 MAGNETIC RESONANCE IMAGING (MRI)         1, 915, 406         0         1, 915, 406         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         5, 816, 777         0         5, 816, 777         59. 00           60. 01         06000 LABORATORY         15, 823, 209         0         15, 823, 209         60. 01           61. 00         06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY         0         0         0         0         60. 00           63. 00         06300 BLOOD STORI NG, PROCESSING & TRANS.         0         0         0         0         62. 00           64. 00         06400 INTRAVHOUS THERAPY         5, 333, 702         0         5, 333, 702         65. 00           65. 00         06500 RESPI RATORY THERAPY         2, 375, 466         2, 275, 466         67. 00<		1	1		_			1
55. 01   05501   INFUSION CENTER   34,954   0   34,954   55. 01		1	1					•
56.00   0500		1			-			1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 915, 406 59. 00 05900 CARDIAC CATHETERI ZATION 5, 816, 777 59. 00 05900 CARDIAC CATHETERI ZATION 5, 816, 777 59. 00 06000 LABORATORY 15, 823, 209 0 15, 823, 209 0 60. 00 60. 01 06000 LABORATORY 15, 823, 209 0 15, 823, 209 0 60. 01 061. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 0 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 102, 016 0 2, 102, 016 62. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 102, 016 0 2, 102, 016 62. 00 63. 00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 0 0 0 0 6500 RESPIRATORY THERAPY 5, 333, 702 0 5, 333, 702 65. 00 06500 RESPIRATORY THERAPY 5, 333, 702 0 5, 333, 702 65. 00 06500 RESPIRATORY THERAPY 2, 824, 583 0 2, 824, 583 66. 00 06600 PHYSI CAL THERAPY 2, 375, 466 0 2, 375, 466 0 67. 00 06700 OCCUPATI IONAL THERAPY 2, 375, 466 0 2, 375, 466 0 68. 00 06800 SPEECH PATHOLOGY 831, 058 0 831, 058 68. 00 06900 ELECTROCARDIO LOGY 1, 451, 862 0 1, 451, 862 69. 00 06901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 646, 798 0 6901 CARDIA C REHAB 646, 798 0 6					-			•
59.00   05900   CARDIAC CATHETERIZATION   5,816,777   0   5,816,777   0   0.0		1						•
60. 00   06000   LABORATORY   15, 823, 209   0   15, 823, 209   0   060. 01   06001   06001   06001   06001   06001   06001   06100   06100   06100   06100   06200   06100   06200   06100   06200   06100   06200					0			
60. 01   06001   BLOOD LABDRATORY   0   0   0   0   0   0   0   0   0					0			
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   2, 102, 016   0   2, 102, 016   0   3. 00   63. 00   63. 00   64. 00   64. 00   64. 00   64. 00   64. 00   64. 00   65. 00   65. 00   65. 00   65. 00   65. 00   66				0	0			•
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   64.00   64.00   06400   INTRAVENDUS THERAPY   0   0   0   0   64.00   65. 00   06500   RESPIRATORY THERAPY   5, 333, 702   0   5, 333, 702   05.00   66. 00   06600   PHYSI CAL THERAPY   2, 824, 583   0   2, 824, 583   06.00   67. 00   06700   OCCUPATI ONAL THERAPY   2, 375, 466   0   2, 375, 466   07.00   68. 00   06800   SPEECH PATHOLOGY   831, 058   0   831, 058   08.00   69. 00   06900   ELECTROCARDI OLOGY   1, 451, 862   0   1, 451, 862   09.00   69. 01   06901   CARDI AC REHAB   646, 798   0   646, 798   0   646, 798   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 869, 556   0   1, 869, 556   70.00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   17, 295, 205   0   17, 295, 205   71.00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   14, 551, 341   0   14, 551, 341   72.00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   26, 233, 870   0   26, 233, 870   73.00   74. 00   07400   RENAL DI ALYSI S   2, 693, 785   0   2, 693, 785   74.00   90. 00   09000   CLI NI C   0   10, 060, 179   0   10, 060, 179   90.00   91. 00   09100   EMERGENCY   18, 998, 115   -512, 825   18, 485, 290   91.00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   0   0   0   0   00   00   00   00		1	1	0		0		
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0				2, 102, 016 0	0	2, 102, 016 0		
66. 00 06600 PHYSI CAL THERAPY 2, 824, 583 0 2, 824, 583 66. 00 6700 0CCUPATI ONAL THERAPY 2, 375, 466 0 2, 375, 466 67. 00 6800 SPEECH PATHOLOGY 831, 058 0 831, 058 68. 00 6900 ELECTROCARDI OLOGY 1, 451, 862 0 1, 451, 862 69. 01 69. 01 06901 CARDI AC REHAB 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 646, 798 0 70. 00 7000 ELECTROENCEPHALOGRAPHY 1, 869, 556 0 1, 869, 556 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 17, 295, 205 0 17, 295, 205 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 14, 551, 341 0 14, 551, 341 72. 00 7300 DRUGS CHARGED TO PATI ENTS 26, 233, 870 0 26, 233, 870 73. 00 7400 RENAL DI ALYSI S 2, 693, 785 0 2, 693, 785 0 73. 00 7400 RENAL DI ALYSI S 2, 693, 785 0 2, 693, 785 0 73. 00 7400 RENAL DI ALYSI S 74. 00 07400 RENAL DI ALYSI S 75. 00 09100 EMERGENCY 18, 998, 115 -512, 825 18, 485, 290 91. 00 09100 EMERGENCY 18, 998, 115 -512, 825 18, 485, 290 91. 00 07400 RENAL DI ALYSI S 75. 00 07400 RENAL DI ALY				0	o	0		
67. 00					О	5, 333, 702		
68. 00					0			
69. 00					0			•
70. 00		1	1		ő			
71. 00					O			
72. 00					0			
73. 00 74. 00 07400   RENAL DI ALYSI S 074. 00 07400   RENAL DI ALYSI S 074. 00 00TPATI ENT SERVI CE COST CENTERS  90. 00 91. 00 91. 00 92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS  101. 00 100   HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS  26, 233, 870 2, 693, 785 0   26, 233, 870 2, 693, 785 0   26, 233, 870 0					_			
OUTPATI ENT   SERVI CE   COST   CENTERS     OPODO   CLI NI C   OPODO   CLI NI C   OPODO   CLI NI C   OPODO   CLI NI C   OPODO   OPODO   CLI NI C   OPODO   O						26, 233, 870		•
90. 00 91. 00 91. 00 92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   10, 060, 179   18, 998, 115   -512, 825   18, 485, 290   91. 00 07   OTHER REI MBURSABLE COST CENTERS  101. 00 10100   HOME   HEALTH   AGENCY   3, 396, 871   0   3, 396, 871   101. 00 SPECI AL PURPOSE COST CENTERS	74. 00			2, 693, 785	0	2, 693, 785		74. 00
91. 00   09100   EMERGENCY   18, 998, 115   -512, 825   18, 485, 290   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0	90 00			10 060 170	ما	10 060 170		90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 3, 396, 871 0 3, 396, 871 101. 00 SPECIAL PURPOSE COST CENTERS								
101.00 10100 HOME HEALTH AGENCY 3, 396, 871 0 3, 396, 871 101.00 SPECIAL PURPOSE COST CENTERS		09200	OBSERVATION BEDS (NON-DISTINCT PART)	2, 112, 110		-, 122, 270		•
SPECIAL PURPOSE COST CENTERS	404 -			0.00:		0.00: ==		101 55
	101.00			3, 396, 871	0	3, 396, 871		101.00
	118. 00			283, 919, 369	-512, 825	283, 406, 544		118. 00
					· •			

Health Financial Systems	METHODIST HOS	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	Provider CCN: 15-0002		Worksheet B			
				From 01/01/2019	Part I			
				To 12/31/2019	Date/Time Prepared: 6/25/2020 8:03 am			
Cost Center Description	Subtotal	Intern &	Total		9, 20, 2020 0. 00 4			
·		Resi dents						
		Cost & Post						
		Stepdown						
		Adjustments						
	24. 00	25. 00	26.00					
NONREI MBURSABLE COST CENTERS								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	91, 958	0	91, 95	8	190. 00			
191. 00 19100 RESEARCH	0	0		0	191.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	45, 665, 447	0	45, 665, 44	7	192. 00			
192. 01 19201 OTHER NON-REIMBURSABLE	896, 168	0	896, 16	8	192. 01			
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	739, 914	0	739, 91	4	192. 02			
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00			
200.00 Cross Foot Adjustments	0	0		0	200.00			
201.00 Negative Cost Centers	0	0		o	201.00			
202.00 TOTAL (sum lines 118 through 201)	331, 312, 856	-512, 825	330, 800, 03	1	202. 00			

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

						) 12/31/2019	6/25/2020 8:0	
				CAPI TAL	·			
		Cook Cooks Doors at a	D:+1	RELATED COSTS	Cubastal	EMBL OVEE	DATA	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	Subtotal	EMPLOYEE	DATA PROCESSI NG	
			Capi tal			BENEFITS DEPARTMENT	PRUCESSI NG	
			Related Costs			DEI ARTIMENT		
			0	1. 00	2A	4. 00	5. 01	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FLXT						1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	80, 408		80, 408	407.000	4.00
5. 01	1	DATA PROCESSING	0	125, 119		2, 183	127, 302 0	5. 01
5. 02 5. 03		PURCHASING RECEIVING AND STORES ADMITTING	0	99, 823 132, 294		477 1, 054	0	5. 02 5. 03
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	0	417, 236		1, 215	0	5. 04
5. 05		OTHER A&G	0	1, 355, 738		5, 900	127, 302	5. 05
5.06	00592	PATIENT TRANSPORTATION	0	0	0	301	0	5.06
7. 00		OPERATION OF PLANT	0	4, 075, 275		2, 087	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	242, 682		0	0	8. 00
9.00		HOUSEKEEPI NG DI ETARY	0	280, 939		2, 436	0	9.00
10. 00 11. 00		CAFETERIA	0	256, 610 179, 401		1, 120 842	0	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	0	86, 453		1, 759	0	13.00
14. 00		CENTRAL SERVICES & SUPPLY	0	487, 992		338	0	14. 00
15.00	01500	PHARMACY	0	258, 094	258, 094	o	0	15.00
16.00		MEDICAL RECORDS & LIBRARY	0	153, 941		1, 074	0	16.00
17.00		SOCIAL SERVICE	0	22, 178		222	0	17.00
17. 01	1	STAFF EDUCATION	0	151, 763		0	0	17. 01
17. 02 21. 00		MEDICAL EDUCATION   I&R SERVICES-SALARY & FRINGES APPRVD	0	5, 092 0		0	0	17. 02 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	60, 817		o	0	22. 00
23. 00		PARAMED ED PROGRAM	0	45, 800		403	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS			·			
30.00		ADULTS & PEDIATRICS	0	4, 264, 357		17, 294	0	30.00
31.00	1	INTENSIVE CARE UNIT	0	270, 442		3, 254	0	31.00
31. 01	1	NEONATAL I CU	0	30, 742		852	0	31.01
40. 00 41. 00	1	SUBPROVIDER - IPF  SUBPROVIDER - IRF	0	54, 078 425, 364		660 1, 452	0	40. 00 41. 00
43. 00		NURSERY	0			673	0	43.00
101 00		LARY SERVICE COST CENTERS		002,020	0027020	3,5		10.00
50.00		OPERATING ROOM	0	812, 076	812, 076	2, 162	0	50.00
50. 01		ENDOSCOPY	0	0		629	0	50. 01
51.00		RECOVERY ROOM	0	198, 039		568	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	95, 344 0	1	1, 585 0	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	722, 382		1, 297	0	54.00
54. 01		RADI OLOGY - ULTRASOUND	0	68, 809		662	0	54. 01
55.00		RADI OLOGY-THERAPEUTI C	0	183, 594		255	0	55.00
55. 01	1	INFUSION CENTER	0	4, 901	4, 901	4	0	55. 01
56.00		RADI OI SOTOPE	0	123, 118		281	0	56. 00
57.00		CT SCAN	0	116, 583		577	0	57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	57, 250 109, 367		222 1, 148	0	58. 00 59. 00
60.00		LABORATORY	0	320, 191		1, 930	0	60.00
60. 01	1	BLOOD LABORATORY	0	0		0	0	60. 01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			0			61.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5, 242		625	0	62.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	0 105, 732	_	0 1, 328	0	64. 00 65. 00
66.00		PHYSI CAL THERAPY	0	167, 052		753	0	66.00
67. 00		OCCUPATI ONAL THERAPY	0	143, 567		646	0	67. 00
68.00	1	SPEECH PATHOLOGY	0	24, 452	1	255	0	68. 00
69.00	06900	ELECTROCARDI OLOGY	0	0	0	393	0	69.00
69. 01		CARDI AC REHAB	0	0	0	225	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	481	0	70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	22, 628	22, 628	0 221	0	72.00
74.00	1	RENAL DIALYSIS	0	59, 673		0	0	74.00
, 00		TIENT SERVICE COST CENTERS		07,070	07,070	<u>~</u> 1		7 00
90.00	09000	CLI NI C	0	1, 037, 182	1, 037, 182	1, 364	0	90. 00
91.00		EMERGENCY	0	368, 455		3, 944	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0	0	0	1, 158	0	101. 00
101.00		AL PURPOSE COST CENTERS		<u> </u>	ı U	1, 138	0	101.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	18, 640, 800	18, 640, 800	68, 309	127, 302	118. 00
					<u> </u>	<u>'</u>	<u> </u>	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2019 To 12/31/2019		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
	0	1. 00	2A	4. 00	5. 01	
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 520	24, 52	0 0		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	363, 662				192. 00
192. 01 19201 OTHER NON-REI MBURSABLE	0	47, 066				192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	122, 491	122, 49	1 91		192. 02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0		201. 00
202.00   TOTAL (sum lines 118 through 201)	0	19, 198, 539	19, 198, 53	9 80, 408	127, 302	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0002

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | 6/25/2020 8:03 am

	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	OTHER A&G	6/25/2020 8:0 PATIENT TRANSPORTATIO	
		5. 02	5. 03	5. 04	5. 05	5. 06	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION	100, 300 117 41 122 11	133, 465 0 0	418, 492 0	1, 489, 062 3, 621	3, 933	4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 296 1	0	0	114, 083 8, 546	0	7. 00 8. 00
9. 00 10. 00 11. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	1, 009 1, 673 3	0		34, 448 21, 660 11, 991	0 0 0	9. 00 10. 00 11. 00
13. 00 14. 00 15. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	65 0 351	0 0	0	22, 744 10, 909	0 0 0	13. 00 14. 00 15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	17 0	0	0	29, 849 16, 537 2, 606	0	16. 00 17. 00
17. 01 17. 02 21. 00	O1701 STAFF EDUCATION   O1702 MEDICAL EDUCATION   O2100   &R SERVICES-SALARY & FRINGES APPRVD	0 3 0	0 0 0	0 0	765 251 1, 123	0 0 0	17. 01 17. 02 21. 00
22. 00 23. 00	02200   &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PROGRAM   INPATIENT ROUTINE SERVICE COST CENTERS	0 18	0		464 3, 688	0	22. 00 23. 00
30. 00 31. 00 31. 01	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 825 2, 161	11, 244 1, 817	5, 726	231, 779 47, 143	1, 540 21	30. 00 31. 00
40. 00 41. 00	O3101 NEONATAL   I CU   O4000 SUBPROVI DER	32 2 255	516 522 755	1, 644 2, 381	10, 635 8, 380 20, 576	0 0 35	31. 01 40. 00 41. 00
43. 00 50. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	3, 245	239 15, 022		10, 709 49, 315	0	43. 00 50. 00
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	1, 772 97 318	1, 981 1, 058	6, 245 3, 336	15, 468 8, 393	88 0	50. 01 51. 00
52. 00 53. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY   O5400   RADI OLOGY-DI AGNOSTI C	0 404	462 0 4, 314	0 13, 600	20, 328 0 28, 183	37 0 392	52. 00 53. 00 54. 00
54. 01 55. 00 55. 01	05401   RADI OLOGY   - ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C   05501   I NFUSI ON CENTER	339 79 2	1, 940 2, 189 24	6, 900	11, 107 12, 518 94	409 23 0	54. 01 55. 00 55. 01
56. 00 57. 00 58. 00	05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 836 779 218	1, 639 13, 215 3, 213	41, 659	12, 014 17, 062 7, 144	215 728 243	56. 00 57. 00 58. 00
59. 00 60. 00 60. 01	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	1, 366 7, 823	7, 250 16, 928 0	22, 856 51, 121	23, 081 61, 743	124 0 0	59. 00 60. 00 60. 01
61. 00 62. 00 63. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	621	1, 052		8, 906	0	61. 00 62. 00 63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 1, 528	0 4, 763	15, 016	0 21, 595	0	64. 00 65. 00
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	18 18 30	828 629 275	1, 983	10, 415 8, 710 3, 350	0 0 0	66. 00 67. 00 68. 00
69. 00 69. 01 70. 00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	39 6 0	2, 698 95 2, 750	299	5, 988 2, 827 7, 823	15 0 30	69. 00 69. 01 70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	31, 100 26, 531	5, 312 2, 853	16, 745 8, 994	67, 880 57, 233	0	71. 00 72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	1, 238 73	16, 197 910	2, 870	85, 588 11, 134	0	73. 00 74. 00
90. 00 91. 00 92. 00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	191 5, 159	2, 708 7, 696		31, 810 65, 833	2 30	90. 00 91. 00 92. 00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	272	371	1, 171	15, 101	0	101. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	99, 511	133, 465		1, 283, 150		118. 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19100 RESEARCH	0	0		124 0		190. 00 191. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

						6/25/2020 8:0	<u>3 am</u>
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	OTHER A&G	PATI ENT	
		RECEIVING AND		COUNTS		TRANSPORTATIO	
		STORES		RECEI VABLE		N	
		5. 02	5. 03	5. 04	5. 05	5. 06	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	788	0	0	200, 438	0	192.00
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	3, 472	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	1	0	0	1, 878	0	192. 02
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
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)	100, 300	133, 465	418, 492	1, 489, 062	3, 933	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Cate/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				Ic	12/31/2019	Date/lime Pre   6/25/2020 8:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04	00570   ADMITTI NG   00580   CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03 5. 04
5. 05	00590 OTHER A&G						5.04
5. 06	00592 PATIENT TRANSPORTATION						5.06
7.00	00700 OPERATION OF PLANT	4, 192, 741					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	78, 799	330, 028				8. 00
9.00	00900 HOUSEKEEPI NG	91, 221	0		070 077		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	83, 321 58, 252	0 0		372, 877 0	256, 427	10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	28, 071	0		ol	6, 598	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	158, 451	562	_,	o	3, 321	1
15.00	01500 PHARMACY	83, 803	0		o	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	49, 985	0		0	8, 262	16. 00
17.00	01700 SOCIAL SERVICE	7, 201	0		0	1, 378	1
17. 01 17. 02	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION	49, 278 1, 653	0	5, 023 169	0	0	17. 01 17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1,000	0	1	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	19, 747	0	- 1	o	0	22.00
23.00	02300 PARAMED ED PROGRAM	14, 871	0		0	2, 915	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 384, 643			294, 504	88, 405	
31.00	03100   NTENSIVE CARE UNIT	87, 813	22, 951		14, 360	14, 146	1
31. 01 40. 00	03101 NEONATAL I CU 04000 SUBPROVI DER - I PF	9, 982 17, 559	0	.,	0 10, 013	3, 527 3, 094	1
41. 00	04100 SUBPROVI DER – TFF	138, 116		.,	32, 713	7, 721	41.00
43. 00	04300 NURSERY	107, 971	4, 745		0	2, 837	43.00
	ANCILLARY SERVICE COST CENTERS		.,	,		,	
50.00	05000 OPERATING ROOM	263, 681	35, 277		0	12, 039	
50. 01	05001 ENDOSCOPY	0	6, 267		0	3, 119	
51.00	05100 RECOVERY ROOM	64, 303	2, 188		0 470	2, 300	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	30, 958	4, 794 0		9, 478 0	7, 746 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	234, 558	_	-	ol	8, 051	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	22, 342			o	3, 192	
55.00	05500 RADI OLOGY-THERAPEUTI C	59, 613	1, 901		o	1, 239	1
55. 01	05501 I NFUSI ON CENTER	1, 591	0		0	24	55. 01
56.00	05600 RADI OI SOTOPE	39, 976	2, 177		0	1, 192	1
57.00	05700 CT SCAN	37, 854	2, 995		0	3, 325	1
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	18, 589 35, 511	1, 293 8, 308		0	1, 230 4, 913	
60.00	06000 LABORATORY	103, 966	0, 300		0	11, 274	60.00
60. 01	06001 BLOOD LABORATORY	0	0		ő	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 702	0	173	0	5, 972	62.00
		0	-		0	0	
64.00		0	0	- 1	0	0	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	34, 331 54, 242	0		0	7, 316	1
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	46, 616			0	3, 359 2, 927	
68. 00		7, 940			Ö	1, 017	1
69. 00	06900 ELECTROCARDI OLOGY	0	493		Ö	2, 249	1
69. 01	06901 CARDI AC REHAB	0	0	0	o	1, 209	69. 01
70.00		0	956	0	0	2, 347	1
71.00		0	0		0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1 010	
	07400 RENAL DIALYSIS	7, 347 19, 376	4, 320	749 1, 975	0	1, 010 0	1
74.00	OUTPATIENT SERVICE COST CENTERS	17, 370	4, 320	1, 7/3	<u> </u>	0	74.00
90.00	09000 CLI NI C	336, 773	12, 503	34, 329	0	6, 467	90.00
	09100 EMERGENCY	119, 637	43, 657	12, 195	11, 809	20, 706	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
404 5	OTHER REIMBURSABLE COST CENTERS	_	-		_1	_	100 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	4, 011, 643	330, 028	391, 592	372, 877	256, 427	118 00
110.00	NONREI MBURSABLE COST CENTERS	4,011,043	330, 026	371, 392	312,011	250, 427	11 10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 962	0	812	0		190. 00
	19100 RESEARCH	0	_	- 1	0		191. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	118, 081	0	12, 037	0	0	192. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

						6/25/2020 8:0	<u> 3 am</u>
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
192. 01 19201	OTHER NON-REIMBURSABLE	15, 282	0	1, 558	0	0	192.01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	39, 773	0	4, 054	0	0	192. 02
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
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)	4, 192, 741	330, 028	410, 053	372.877	256, 427	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Cate/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				10	12/31/2019	Date/lime Pre 6/25/2020 8:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
		13. 00	14. 00	15. 00	16.00	17. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMITTING						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05 5. 06	O0590 OTHER A&G   O0592 PATIENT TRANSPORTATION						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	148, 551					11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	146, 551	677, 725				14.00
15. 00	01500 PHARMACY	o	0				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	O	0	0	234, 911		16.00
17. 00	01700 SOCI AL SERVI CE	1, 204	0	0	0	35, 523	1
17. 01	01701 STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02 21. 00	01702 MEDICAL EDUCATION   02100   1&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	o	0		ő	0	•
23.00	02300 PARAMED ED PROGRAM	2, 548	0	0	0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	77, 281	0		19, 918	28, 367	30.00
31. 00 31. 01	03100   INTENSI VE CARE UNIT   03101   NEONATAL   I CU	12, 366 3, 084	0	0	3, 218 914	0	31.00 31.01
40. 00	04000 SUBPROVI DER - I PF	2, 705	0	0	924	0	1
41.00	04100 SUBPROVI DER - I RF	6, 750	0	0	1, 338	5, 684	1
43.00	04300 NURSERY	2, 480	0	0	424	0	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	40 504			07 740	_	F0 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 ENDOSCOPY	10, 524 2, 726	0		26, 610 3, 510	0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	2, 010	0		1, 874	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 772	0	0	818	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0	0	7, 642	0	
54. 01 55. 00	05401   RADI OLOGY - ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C	0	0	0	3, 437 3, 877	0	54. 01 55. 00
55. 00	05501 I NFUSI ON CENTER	0	0	0	3, 677	0	55. 00
56. 00	05600 RADI OI SOTOPE	o	0	Ö	2, 904	Ō	56.00
57.00	05700 CT SCAN	0	0	0	23, 410	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5, 692	0	58.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	0	20 450	12, 844 28, 472	0	59. 00 60. 00
	06001 BLOOD LABORATORY	0	0	30, 650	20, 472	0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		· ·		J		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	0	0	1, 863	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0 420	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	8, 438 1, 467	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	0	Ö	1, 114	0	67.00
68.00	06800 SPEECH PATHOLOGY	O	0	0	486	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	4, 779	0	69.00
69. 01	06901 CARDI AC REHAB	0	0	0	168	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	365, 737	0	4, 871 9, 409	0	70.00 71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	ő	311, 988		5, 054	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		28, 693	0	73.00
74. 00	07400 RENAL DIALYSIS	0	0	0	1, 613	0	74.00
00.00	OUTPATIENT SERVICE COST CENTERS		^		4 707	^	00.00
	09000 CLI NI C 09100 EMERGENCY	0 18, 101	0		4, 797 13, 632	0 1, 472	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 101	Ü		13, 032	1,4/2	92.00
55	OTHER REIMBURSABLE COST CENTERS						]
101.00	10100 HOME HEALTH AGENCY	0	0	721	658	0	101.00
110 01	SPECIAL PURPOSE COST CENTERS	140 551	/77 705	075 450	224 244	25 522	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	148, 551	677, 725	375, 159	234, 911	35, 523	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	o	0		o		191.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

						6/25/2020 8:0	03 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16.00	17. 00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	5, 480	0	(	192.00
192. 01 1920°	OTHER NON-REIMBURSABLE	0	0	0	0	(	192.01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	(	192.02
193. 00 19300	NONPALD WORKERS	0	0	0	0	(	193.00
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)	148 551	677 725	380 639	234 911	35 523	3 202 00

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

				'	0 12/31/2019	6/25/2020 8: 0	
			<u> </u>	INTERNS &	RESI DENTS		
	Cost Conton Description	CTAFF	MEDLCAL	CEDVICES SALA	CEDVI CEC OTHE	DADAMED ED	
	Cost Center Description	STAFF EDUCATION	MEDI CAL EDUCATI ON	RY & FRINGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PROGRAM	
		17. 01	17. 02	21.00	22.00	23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER A&G						5. 05
5.06	00592 PATI ENT TRANSPORTATI ON						5.06
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVI CES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
17. 01	01701 STAFF EDUCATION	206, 829					17. 01
17. 02	01702 MEDICAL EDUCATION	0	7, 168				17. 02
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1, 123			21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		83, 041		22. 00
23. 00	02300 PARAMED ED PROGRAM	272	0			72, 031	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			ı			
	03000 ADULTS & PEDIATRICS	94, 238	0				30.00
	03100 INTENSIVE CARE UNIT	17, 785	0				31.00
31. 01 40. 00	03101 NEONATAL I CU	1, 520	0				31.01
41. 00	04000   SUBPROVI DER   -   I PF   04100   SUBPROVI DER   -   I RF	1, 637 8, 941	0				40. 00 41. 00
43. 00	04300 NURSERY	4, 645	0				43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	4, 043	0				43.00
50. 00	05000 OPERATING ROOM	12, 764	0				50.00
50. 01	05001 ENDOSCOPY	3, 991	0				50. 01
51.00	05100 RECOVERY ROOM	1, 581	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 117	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 565	0				54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	848	0				54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	668	0				55. 00
55. 01	05501   NFUSI ON CENTER	0	0				55. 01
56.00	05600 RADI OI SOTOPE	15	0	1			56.00
57. 00	05700 CT SCAN	1, 715	0	•			57.00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	104 7, 509	0				58.00
60. 00	06000 LABORATORY	313	0				59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	0	0	1			60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	221	0				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	06400 I NTRAVENOUS THERAPY	o	0				64.00
65. 00	06500 RESPIRATORY THERAPY	4, 238	0				65.00
66.00	06600 PHYSI CAL THERAPY	171	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	177	0				67.00
68.00	06800 SPEECH PATHOLOGY	157	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	246	0				69. 00
69. 01	06901 CARDI AC REHAB	0	0				69. 01
	07000 ELECTROENCEPHALOGRAPHY	263	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72.00
	07300 DRUGS CHARGED TO PATIENTS	33	0	•			73.00
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0				74.00
90. 00	09000 CLINIC	664	0				90.00
	09100 EMERGENCY	21, 227	7, 168	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	21,221	7, 100				92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS						1 .2. 50
101.00	10100 HOME HEALTH AGENCY	4, 225	0				101.00
50	SPECIAL PURPOSE COST CENTERS	,					1
118.00		202, 850	7, 168	0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002
From 01/01/2019
To 12/31/2019
Date/Time Prepared: 6/25/2020 8: 03 am

					<u>  6/25/2020_8: 0</u>	<u>3 am </u>
			INTERNS &	RESI DENTS		
Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
·	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	17. 01	17. 02	21. 00	22. 00	23.00	
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3, 964	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	15	0				192. 02
193.00 19300 NONPALD WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			1, 123	83, 041	72, 031	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	206, 829	7, 168	1, 123	83, 041	72, 031	202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

						То	12/31/2019 Date/Time Pre 6/25/2020 8:0	
		Cost Center Description	Subtotal	Intern &	Total		, 9, 20, 2020 0. 0	
				Residents Cost & Post				
				Stepdown				
				Adjustments				
	CENEE	RAL SERVICE COST CENTERS	24. 00	25. 00	26. 00			
1. 00	_	CAP REL COSTS-BLDG & FIXT						1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	1	DATA PROCESSING						5. 01
5. 02	1	PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 03 5. 04
5. 05		OTHER A&G						5. 05
5.06		PATIENT TRANSPORTATION						5.06
7.00	1	OPERATION OF PLANT						7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00		DI ETARY						10.00
11. 00		CAFETERI A						11.00
13.00		NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY						14. 00 15. 00
16.00	1	MEDICAL RECORDS & LIBRARY						16.00
17. 00	1	SOCIAL SERVICE						17. 00
17. 01		STAFF EDUCATION						17. 01
17. 02		MEDICAL EDUCATION						17. 02
21. 00 22. 00	1	&R SERVICES-SALARY & FRINGES APPRVD     &R SERVICES-OTHER PRGM COSTS APPRVD						21.00 22.00
23. 00		PARAMED ED PROGRAM						23.00
	_	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	6, 836, 028	0				30.00
31. 00 31. 01	1	INTENSIVE CARE UNIT   NEONATAL ICU	512, 154 64, 448	0				31.00 31.01
40. 00		SUBPROVI DER - I PF	103, 008	0	,			40.00
41.00		SUBPROVI DER - I RF	688, 800	0				41.00
43. 00	-	NURSERY	479, 415	0	479, 4	15		43.00
50.00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 316, 948	0	1, 316, 9	48		50.00
50. 01	1	ENDOSCOPY	45, 796	0				50. 01
51.00		RECOVERY ROOM	292, 302	0				51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	192, 368	0		68		52.00 53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	1, 057, 125	0		25		54.00
54. 01	1	RADI OLOGY - ULTRASOUND	123, 931	0				54. 01
55.00		RADI OLOGY-THERAPEUTI C	278, 933	0	, .			55.00
55. 01 56. 00		I NFUSION CENTER RADIOI SOTOPE	6, 922	0				55. 01 56. 00
57.00		CT SCAN	195, 610 263, 761	0				57.00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107, 222	Ö				58.00
59. 00		CARDI AC CATHETERI ZATI ON	237, 897	0	237, 8			59.00
60. 00 60. 01		LABORATORY	645, 009	0				60. 00 60. 01
61. 00	1	BLOOD LABORATORY   PBP CLINICAL LAB SERVICES-PRGM ONLY	U	0		0		61.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	29, 692	0	29, 6	92		62.00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
64. 00 65. 00		INTRAVENOUS THERAPY RESPIRATORY THERAPY	0 207, 786	0	207, 7	0		64. 00 65. 00
66.00		PHYSI CAL THERAPY	246, 549	0	246, 5			66.00
67. 00		OCCUPATI ONAL THERAPY	211, 706	0	211, 7			67.00
68. 00	1	SPEECH PATHOLOGY	39, 637	0	39, 6			68.00
69.00	1	ELECTROCARDI OLOGY	25, 404	0	25, 4			69.00
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	4, 829 28, 189	0	4, 8 28, 1			69. 01 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	496, 183	Ö				71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	412, 653	0				72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	558, 553 101, 944	0				73.00 74.00
74.00		TIENT SERVICE COST CENTERS	101, 944	0	101, 9	44		74.00
90.00	09000	CLI NI C	1, 477, 327	0	1, 477, 3	27		90.00
		EMERGENCY	744, 981	0		81		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
101.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	23, 677	0	23, 6	77		101.00
50		AL PURPOSE COST CENTERS						
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	18, 056, 787	0	18, 056, 7	87		118. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0002	Period: From 01/01/2019 To 12/31/2019		
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26. 00			
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 418	0	33, 41	18	[1	190. 00
191. 00 19100 RESEARCH	0	0		0	[1	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	716, 458	0	716, 45	58	1	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	67, 378	0	67, 37	78	1	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	168, 303	0	168, 30	03	1	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0	1	193. 00
200.00 Cross Foot Adjustments	156, 195	0	156, 19	95	2	200.00
201.00 Negative Cost Centers	0	0		0	2	201. 00
202.00 TOTAL (sum lines 118 through 201)	19, 198, 539	0	19, 198, 53	39	2	202. 00

				T	o 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		CAPI TAL				0/23/2020 0.0	J dill
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
		(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND STORES	(GROSS	
			DEPARTMENT (GROSS	(MACHINE TIME)	(PURCHASE	CHARGES)	
			SALARI ES)	I I WE	REQUISITIONS)		
		1. 00	4.00	5. 01	5. 02	5. 03	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT	1, 410, 133	147 0/5 /00				1.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	5, 906 9, 190	147, 265, 628 3, 998, 413				4. 00 5. 01
5. 01	00560 PURCHASING RECEIVING AND STORES	7, 130	873, 756		l .		5. 02
5. 03	00570 ADMITTING	9, 717	1, 930, 169			1, 266, 100, 952	5.03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 646	2, 224, 383		15, 621	0	5. 04
5. 05	00590 OTHER A&G	99, 579	10, 806, 604		46, 369	0	5. 05
5. 06	00592 PATI ENT TRANSPORTATI ON	0	550, 369		4, 182	0	5.06
7.00	00700 OPERATION OF PLANT	299, 329	3, 821, 698		490, 578	0	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	17, 825 20, 635	0 4, 461, 333		358 382, 179	0	8. 00 9. 00
10.00	1 1	18, 848	2, 051, 059		633, 558	0	10.00
11. 00		13, 177	1, 542, 748		1, 044	Ö	11.00
13.00	01300 NURSING ADMINISTRATION	6, 350	3, 222, 427	0	24, 588	0	13.00
14.00		35, 843	619, 842		0	0	14. 00
15. 00		18, 957	0	· ·	133, 035	0	15.00
16.00		11, 307	1, 966, 875		6, 425	0	16.00
17. 00 17. 01	1 1	1, 629 11, 147	407, 414 0		0	0	17. 00 17. 01
17. 01	1 1	374	0	· ·	1, 113	Ö	17. 02
21.00	1 1	0	0	0	O	0	21.00
22. 00		4, 467	0		0	0	22. 00
23. 00		3, 364	737, 359	0	6, 832	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	313, 217	31, 670, 464	0	2, 205, 612	107, 083, 680	30.00
31. 00	1 1	19, 864	5, 959, 503		818, 156		
31. 01	1 1	2, 258	1, 560, 179		12, 033		
40.00	1	3, 972	1, 208, 668		943	4, 966, 991	
41.00	1	31, 243	2, 659, 975		96, 521	7, 194, 491	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	24, 424	1, 232, 034	0	154, 273	2, 277, 786	43.00
50.00		59, 647	3, 960, 153	0	1, 228, 586	143, 066, 646	50.00
50. 01	1	0	1, 152, 017		670, 968	18, 868, 420	
51.00		14, 546	1, 039, 418		36, 912	10, 077, 869	51.00
52.00	1	7, 003	2, 903, 655		120, 375	4, 396, 544	
53. 00 54. 00		0 53, 059	0 2, 376, 258		0 152, 802	0 41, 086, 561	53. 00 54. 00
54. 01		5, 054	1, 211, 922		128, 539	18, 476, 481	
55.00		13, 485	467, 047	0	29, 917	20, 844, 494	
55. 01		360	8, 099		764	232, 368	
56.00		9, 043	513, 737				
57.00		8, 563	1, 057, 425		294, 829 82, 657		
58. 00 59. 00	1 1	4, 205 8, 033	406, 713 2, 102, 949			30, 600, 361 69, 051, 548	
60.00		23, 518	3, 534, 845				60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
61.00	1						61.00
62.00		385	1, 144, 908	1		10, 016, 410	
63. 00 64. 00		0	0	0	0	0	63. 00 64. 00
65.00	1	7, 766	2, 431, 703		578, 662	45, 364, 538	
66.00	1 1	12, 270	1, 379, 574		6, 903	7, 884, 598	
67. 00		10, 545	1, 183, 313		7, 004		
68.00		1, 796	466, 863		11, 213		
69. 00 69. 01		0	719, 542		14, 649	25, 691, 629 903, 058	
70.00			411, 500 880, 816		2, 414 0	26, 186, 485	
71. 00	1 1		0	i e	11, 776, 424		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10, 045, 657	27, 173, 221	72. 00
73.00		1, 662	405, 415			154, 261, 776	
/4.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	4, 383	164	0	27, 732	8, 671, 001	74. 00
90.00	09000 CLINIC	76, 181	2, 498, 814	0	72, 316	25, 791, 599	90.00
91.00	09100 EMERGENCY	27, 063	7, 223, 109				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
101 01	OTHER REIMBURSABLE COST CENTERS O 10100 HOME HEALTH AGENCY		0 404 774	_	100 074	2 527 542	101 00
101.00	UNITO ONE MEALIN AGENCY	0	2, 121, 771	0	102, 874	3, 536, 512	1101.00

Health Finar	ncial Systems	METHODI ST HOSE	PITALS, INC		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nared.
					10 12/01/201/	6/25/2020 8: 0	
		CAPI TAL					
	Cost Center Description	RELATED COSTS BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMITTING	
	cost center bescription	(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	
		(SQUARE FEET)	DEPARTMENT	(MACHI NE	STORES	CHARGES)	
			(GROSS	TIME)	(PURCHASE	0.1.1.1020)	
			SALARI ES)	,	REQUISITIONS)		
		1. 00	4. 00	5. 01	5. 02	5. 03	
	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 369, 167	125, 107, 002	10	37, 679, 742	1, 266, 100, 952	118.00
	I MBURSABLE COST CENTERS	1 001	0			0	100.00
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 801 0	0		0		190. 00 191. 00
	PHYSICIANS' PRIVATE OFFICES	26, 711	21, 991, 859		298, 498		191.00
	OTHER NON-REIMBURSABLE	3, 457	21, 991, 009 N		32		192.00
	FAMILY HEALTH/GARY COMM HEALTH	8, 997	166, 767		92 425		192.02
	NONPALD WORKERS	0	0		0 0		193. 00
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	19, 198, 539	31, 675, 809	11, 588, 56	4, 106, 092	2, 926, 934	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	13. 614701	0.215002	115, 885. 6700	0. 108116	0. 002312	202 00
203.00	Cost martipirer (wkst. b, rait i)	13.014701	0. 213073	113, 003. 0700	0. 100110	0.002312	203.00
204. 00	Cost to be allocated (per Wkst. B,		80, 408	127, 30	100, 300	133, 465	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000546	1, 273. 02000	0. 002641	0. 000105	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	(per wkst. B-2)  NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
I	1. 2. 22	ı I	l e e e e e e e e e e e e e e e e e e e		Į.	I	1

Heal th	Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	
	Cook Cooker Doorwinding	CACHI EDI NO (AC	December	OTHER ASC	DATIENT	6/25/2020 8: C	3 am
	Cost Center Description	CASHI ERI NG/AC COUNTS	n		PATI ENT TRANSPORTATI O	OPERATION OF PLANT	
		RECEI VABLE	"	(ACCOM. COST)	N N	(SQUARE FEET)	
		(GROSS			(NUMBER OF	(,	
		CHARGES)			TRI PS)		
	I	5. 04	5A. 05	5. 05	5. 06	7. 00	
1 00	GENERAL SERVICE COST CENTERS	1		ı		I	1 00
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 266, 100, 952					5. 04
5. 05	00590 OTHER A&G	0	-35, 779, 783				5. 05
5. 06	00592 PATIENT TRANSPORTATION	0	0	718, 61			5.06
7. 00 8. 00	00700 OPERATION OF PLANT	0	0	22, 639, 95			
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	1, 696, 00 6, 836, 24			•
10. 00	01000 DI ETARY	Ö	0	4, 298, 56			•
11. 00	01100 CAFETERI A	0	0	2, 379, 54		•	•
13.00	01300 NURSING ADMINISTRATION	0	0	4, 513, 54	9 0	6, 350	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	2, 164, 82			
15. 00	01500 PHARMACY	0	0	-,,			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	3, 281, 85			
17.00	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	0	0	517, 22 151, 76			17.00
	01701 STAFF EDUCATION 01702 MEDI CAL EDUCATION	0	0	49, 82		11, 147 374	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0			l .	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	o	0			<b>l</b>	1
23.00	02300 PARAMED ED PROGRAM	0	0	731, 80	4 0	3, 364	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	107, 083, 680	0				
31.00	03100 I NTENSI VE CARE UNI T	17, 300, 097	0	9, 355, 68			
40. 00	03101   NEONATAL   I CU   04000   SUBPROVI DER -   I PF	4, 913, 332 4, 966, 991	0			l '	1
41. 00	04100 SUBPROVI DER - I RF	7, 194, 491	0				1
43. 00	04300 NURSERY	2, 277, 786	0				1
	ANCILLARY SERVICE COST CENTERS					·	]
50.00	05000 OPERATING ROOM	143, 066, 646	0			•	1
50. 01	05001 ENDOSCOPY	18, 868, 420	0				50.01
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	10, 077, 869 4, 396, 544	0	1, 665, 51 4, 034, 13		.,	1
52.00	05300 ANESTHESI OLOGY	4, 396, 544	0		0 414	7,003	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	41, 086, 561	0		-	1	•
54. 01	05401 RADI OLOGY - ULTRASOUND	18, 476, 481	0	2, 204, 13			
55.00	05500 RADI OLOGY-THERAPEUTI C	20, 844, 494	0	2, 484, 19	9 259	13, 485	55.00
55. 01	05501 I NFUSI ON CENTER	232, 368	0				55. 01
	05600 RADI OI SOTOPE	15, 612, 820	0	2, 384, 10			
	05700 CT SCAN	125, 859, 121	0	-,,			57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	30, 600, 361 69, 051, 548	0	1, 417, 73 4, 580, 41			58. 00 59. 00
60. 00	06000 LABORATORY	156, 224, 313	0	12, 252, 93			
60. 01	06001 BLOOD LABORATORY	0	0	12,202,70	o o	l '	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 016, 410	0	1, 767, 43	1 0	385	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1	
64.00	06400   NTRAVENOUS THERAPY	0	0	4 005 50	0	1	
65.00	06500 RESPIRATORY THERAPY	45, 364, 538	0	4, 285, 53			
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	7, 884, 598 5, 990, 640	0	2, 066, 81 1, 728, 58			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 614, 967	0	664, 77			68.00
69. 00	06900 ELECTROCARDI OLOGY	25, 691, 629	0	1, 188, 25		l '	1
69. 01	06901 CARDI AC REHAB	903, 058	0	561, 08			1
70. 00	07000 ELECTROENCEPHALOGRAPHY	26, 186, 485	0	1, 552, 47	0 341	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50, 588, 056	0	13, 470, 98			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 173, 221	0	11, 358, 07			
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	154, 261, 776 8, 671, 001	0				•
74.00	OUTPATIENT SERVICE COST CENTERS	8, 071, 001		2, 204, 30	<u> </u>	4, 303	74.00
90.00		25, 791, 599	0	6, 312, 74	1 17	76, 181	90.00
91.00		73, 292, 539	Ō				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				_		ļ
101.00	10100 HOME HEALTH AGENCY	3, 536, 512	0	2, 996, 86	0 0	0	101.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1 266 100 952	-35, 779, 783	254, 669, 39	4 44, 058	907, 468	118 00
. 13. 00	- 1 1005.5 (John of Eritzo I till ough 117)	, ., 255, 156, 752	55, 7, 7, 705	231, 307, 37	-, ++, 050	, ,,,,,,,	1 5. 60

5.						6.5. 0110	
	ancial Systems	METHODIST HOS				u of Form CMS-	
COST ALLOC	ATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	paradi
					10 12/31/2019	6/25/2020 8: 0	
	Cost Center Description	CASHLERI NG/AC	Reconciliatio	OTHER A&G	PATI FNT	OPERATION OF	U UIII
	5551 551151 25551 Ft. 511	COUNTS	n	(ACCUM. COST)		PLANT	
		RECEI VABLE		(7.000	N	(SQUARE FEET)	
		(GROSS			(NUMBER OF	(040/1112 / 221)	
		CHARGES)			TRI PS)		
		5. 04	5A. 05	5. 05	5. 06	7. 00	
NONE	REIMBURSABLE COST CENTERS						
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24, 53	1 0	1, 801	190.00
•	DO RESEARCH	0	0		0	0	191.00
192, 00 1920	OO PHYSICIANS' PRIVATE OFFICES	0	0	39, 777, 38 <sup>-</sup>	1 0	26, 711	192.00
192, 01 1920	01 OTHER NON-REIMBURSABLE	0	0	689, 02			192. 01
•	2 FAMILY HEALTH/GARY COMM HEALTH	0	0	372, 74			192. 02
	OO NONPALD WORKERS	0	0		0		193.00
200.00	Cross Foot Adjustments	1	_			_	200.00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	7, 618, 197		35, 779, 78	805, 613	25, 380, 951	
202.00	Part I)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			300,0.0	20,000,701	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 006017		0. 12106	18. 285283	26. 760904	203.00
204. 00	Cost to be allocated (per Wkst. B,	418, 492	l	1, 489, 06		4, 192, 741	
2011.00	Part II)	1.07.72		1, 10,, 00.	0,700	17 1727 7 11	20 11 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000331		0. 005039	0. 089269	4, 420699	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)						
'	,	1	Į.	1	į.	ı	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0002 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS ADMI NI STRATI O (SQUARE FEET) (PRODUCTI VE (POUNDS OF SERVED) HOURS) Ν (DI RECT NURS. LAUNDRY) HRS.) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.04 5.05 00590 OTHER A&G 5.05 00592 PATIENT TRANSPORTATION 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1,830,620 8.00 9.00 00900 HOUSEKEEPI NG 909, 974 9.00 01000 DI ETARY 18, 848 355, 755 10.00 10.00 0 2, 559, 548 01100 CAFETERI A 13, 177 11.00 0 0 11.00 13.00 01300 NURSING ADMINISTRATION 0 6, 350 0 65, 855 1, 696, 190 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 35, 843 0 33, 147 0 14.00 3.118 01500 PHARMACY 0 15.00 0 18.957 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 11, 307 0 82, 469 0 16.00 01700 SOCIAL SERVICE 0 17.00 1, 629 0 13, 752 13, 752 17.00 0 01701 STAFF EDUCATION 0 17.01 11, 147 17.01 0 0 0 01702 MEDICAL EDUCATION 0 17.02 374 0 0 17.02 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 4, 467 0 22.00 0 23 00 02300 PARAMED ED PROGRAM 0 29.094 29 094 23 00 3, 364 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 776, 827 313, 217 280, 980 882, 418 882, 418 30.00 31.00 03100 INTENSIVE CARE UNIT 127, 304 13, 701 141, 197 141, 197 31.00 19,864 03101 NEONATAL ICU 35, 209 31 01 2 258 35, 209 31 01 0 0 04000 SUBPROVI DER - I PF 40.00 0 3, 972 9, 553 30, 886 30,886 40.00 77, 070 04100 SUBPROVI DER - I RF 125, 582 41.00 31, 243 31, 211 77,070 41.00 43.00 04300 NURSERY <u>26</u>, 318 24, 424 0 28, 314 28, 314 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 195, 676 59, 647 0 120, 169 120, 169 50.00 05001 ENDOSCOPY 34, 762 50.01 0 31, 128 31, 128 50.01 22, 955 22, 955 51.00 05100 RECOVERY ROOM 12.138 14.546 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 9, 043 77, 319 52 00 26, 589 7,003 77, 319 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 48, 970 53, 059 0 80, 365 0 54.00 05401 RADI OLOGY - ULTRASOUND 5, 054 54.01 13.604 0 31.858 54.01 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 10, 542 13, 485 12, 368 0 55.00 55.01 05501 INFUSION CENTER 360 0 239 0 55.01 05600 RADI OI SOTOPE 12,075 9, 043 56,00 0 11.898 0 56,00 0 57 00 05700 CT SCAN 16, 615 8, 563 33, 189 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 7, 172 4, 205 0 12, 281 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 46, 086 8, 033 49,042 0 59.00 06000 LABORATORY 23, 518 0 60.00 0 112, 537 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 385 0 59, 613 O 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 7,766 0 73,026 0 65.00 06600 PHYSI CAL THERAPY 581 12, 270 0 33, 524 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 10, 545 0 67.00 3, 144 29, 216 0 67.00 0 68.00 06800 SPEECH PATHOLOGY Ω 1, 796 10, 147 0 68.00 06900 ELECTROCARDI OLOGY 69.00 2,734 22, 452 0 69.00 06901 CARDI AC REHAB 0 12,069 69.01 C 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 5, 302 C 23, 431 0 70.00 71.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 1 662 0 10,081 0 73 00 0 0 07400 RENAL DIALYSIS 74.00 23, 965 4, 383 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 69, 354 76, 181 C 64, 551 0 90.00 09100 EMERGENCY 27, 063 11, 267 206, 679 91 00 206, 679 91.00 242, 162 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 830, 620 1, 696, 190 118. 00 869, 008 355, 755 2, 559, 548

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019		
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE FEET)	(MEALS	(PRODUCTI VE	ADMINISTRATIO	
	(POUNDS OF		SERVED)	HOURS)	N (DIDECT NUDC	
	LAUNDRY)				(DI RECT NURS. HRS. )	
	8. 00	9. 00	10.00	11. 00	13. 00	
NONREI MBURSABLE COST CENTERS	0.00	7. 00	10.00	11.00	13.00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	26, 711		0 0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	3, 457		0 0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	8, 997		0 0	0	192. 02
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	2, 378, 346	8, 216, 111	5, 493, 55	3, 139, 232	5, 368, 036	202.00

1. 299202

330, 028

0. 180282

9. 028951

410, 053

0. 450621

15. 441947

372, 877

1. 048129

1. 226479

256, 427

0. 100184

3. 164761 203. 00 148, 551 204. 00

0. 087579 205. 00

206.00

207.00

Part I)

Part II)

H)

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)

203.00

204.00

205.00

206.00

207.00

				10	3 12/31/2019	6/25/2020 8: 0	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
		REQUIS.)	15.00	CHARGES)	17.00	17.01	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	17. 01	
1. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 01 17. 02 21. 00 22. 00 23. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01701 SOCIAL SERVICE 01701 STAFF EDUCATION 01702 MEDICAL EDUCATION 01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	21, 822, 081 0 0 0 0 0 0 0	16, 537, 962 0 0 0 0 0 0 0	1, 266, 100, 952 0 0 0 0 0 0	700 0 0 0 0	107, 802 0 0 0	1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.01 17.02 21.00 22.00 23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0	107, 083, 680	559	49, 119	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	· ·	1
31. 01	03101 NEONATAL I CU	0	0	4, 913, 332	0	792	31.01
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF		0	4, 966, 991 7, 194, 491	0 112	853 4, 660	40. 00 41. 00
43.00	04300 NURSERY	0	0		0		43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	l ol	0	143, 066, 646	0	6, 653	50.00
50. 01	05001 ENDOSCOPY	o o	0		0		
51.00	05100 RECOVERY ROOM	0	0		0	~	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	4, 396, 544 0	0		52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0	41, 086, 561	0	-	1
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0	,	0	442	54. 01
55. 00 55. 01	05500  RADI OLOGY-THERAPEUTI C   05501  I NFUSI ON CENTER	0	0	20, 844, 494 232, 368	0	348 0	55. 00 55. 01
56. 00	05600 RADI OI SOTOPE	o	0		0		56.00
57.00	05700 CT SCAN	0	0	125, 859, 121	0		57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	,,	0		58. 00 59. 00
60.00		o	1, 331, 688	,,	0		
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10, 016, 410	0	115	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	O	0	0	0	63.00
64.00	06400   NTRAVENOUS THERAPY	0	0	0	0		64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	45, 364, 538 7, 884, 598	0	2, 209 89	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	o	O	5, 990, 640	0	92	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	2, 614, 967	0	82	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0	25, 691, 629 903, 058	0	128 0	ı
70.00	1	o	O	26, 186, 485	0	137	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 776, 424	0	50, 588, 056	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	10, 045, 657	0 14, 936, 845	,,	0	0 17	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	ō	0		0		74.00
90.00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	0	25, 791, 599	0	346	90.00
91.00		0	0		29		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY	O	31, 345	3, 536, 512	0	2 202	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	J J	51, 340		0	2, 202	]
118. 00		21, 822, 081	16, 299, 878	1, 266, 100, 952	700	105, 728	118. 00

Health Financial Systems	METHODIST HOSE	DITALS INC		Inlia	u of Form CMS-2	2552_10
COST ALLOCATION - STATISTICAL BASIS	WETHODIST HOSE	Provi der CO	CN: 15-0002 F	Peri od:	Worksheet B-1	2332-10
			F	rom 01/01/2019 o 12/31/2019		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	STAFF	
	SERVICES &	(COSTED	RECORDS &	SERVI CE	EDUCATI ON	
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(TIME SPENT)	
	(COSTED REQUIS.)		(GROSS CHARGES)			
	14. 00	15. 00	16. 00	17. 00	17. 01	
NONREI MBURSABLE COST CENTERS		10.00	10.00	17100	17.51	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0	190. 00
191. 00 19100 RESEARCH	0	0	(	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	238, 084	(	0		192. 00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	(	0		192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	(	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	(	0	0	193. 00
200.00 Cross Foot Adjustments						200.00
201. 00 Negative Cost Centers	0 754 450	7 040 004			F/0 007	201.00
202.00 Cost to be allocated (per Wkst. B,	3, 754, 458	7, 319, 226	4, 185, 005	698, 535	569, 087	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 172049	0. 442571	0. 003305	997. 907143	5. 279002	202 00
204.00 Cost to be allocated (per Wkst. B,	677, 725	380, 639				
Part II)	011,123	300, 037	254, 711	33, 323	200, 027	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 031057	0. 023016	0. 000186	50. 747143	1. 918601	205. 00
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)						l

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0002 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am INTERNS & RESIDENTS Cost Center Description MEDI CAL SERVI CES-SALA SERVI CES-OTHE PARAMED ED **FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER A&G 5.05 00592 PATIENT TRANSPORTATION 5.06 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17 01 17 01 01702 MEDICAL EDUCATION 17.02 100 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 100 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 100 22.00 02300 PARAMED ED PROGRAM 100 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 03000 ADULTS & PEDIATRICS C 30.00 0 03100 INTENSIVE CARE UNIT 31.00 0 0 0 31.00 0 31 01 03101 NEONATAL ICU 0 0 31.01 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 50.01 05001 ENDOSCOPY 000000000000000 0 0 0 50.01 0 05100 RECOVERY ROOM 0 51.00 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 55.01 05501 INFUSION CENTER 0 0 55.01 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 0 57.00 05700 CT SCAN C 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 06000 LABORATORY 0 0 60.00 C 60 00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 ol 62.00 0000000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 66 00 06600 PHYSI CAL THERAPY 0 0 66 00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 C 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 06901 CARDI AC REHAB 0 69.01 C 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 0 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90 00 O 90 00 0 0 09000 CLI NI C 91.00 09100 EMERGENCY 100 100 100 100 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 100 100 100 118.00

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2019	Worksheet B-1		
				To 12/31/2019	Date/Time Pre 6/25/2020 8:0		
		INTERNS &	RESI DENTS				
Cost Center Description		SERVI CES-SALA					
	EDUCATI ON (ASSI GNED	RY & FRI NGES (ASSI GNED	(ASSI GNED	(ASSI GNED			
	TIME)	TIME)	I TIME)	TIME)			

			INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL EDUCATI ON (ASSI GNED TI ME)	RY & FRINGES (ASSIGNED TIME)	SERVI CES-OTHE R PRGM COSTS (ASSI GNED TI ME)	PARAMED ED PROGRAM (ASSI GNED TI ME)	
	NONREI MBURSABLE COST CENTERS	17. 02	21. 00	22. 00	23. 00	
190. 00 191. 00 192. 00 192. 01 192. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19201 OTHER NON-REIMBURSABLE 19202 FAMILY HEALTH/GARY COMM HEALTH 19300 NONPAID WORKERS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	190. 00 191. 00 192. 00 192. 01 192. 02 193. 00 200. 00 201. 00 202. 00
203. 00 204. 00 205. 00	Cost to be allocated (per Wkst. B, Part II)	692. 480000 7, 168 71. 680000	1, 123	83, 041		203. 00 204. 00 205. 00
206. 00 207. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0. 000000	206. 00 207. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	Period: Worksheet C
		From 01/01/2019 Part I

				-	Го 12/31/2019	Date/Time Pre 6/25/2020 8:0	pared: 3 am
			Title	XVIII	Hospi tal	PPS	J dili
					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	
	SERVICE COST CENTERS						
30. 00 03000 ADULTS & PED		73, 514, 433		73, 514, 43	12, 477	73, 526, 910	30.00
31.00 03100 INTENSIVE CA	ARE UNIT	12, 306, 663		12, 306, 66	3 0	12, 306, 663	31.00
31. 01   03101   NEONATAL   CL	J	2, 621, 975		2, 621, 97	5 0	2, 621, 975	31.01
40. 00   04000   SUBPROVI DER	- IPF	2, 310, 655		2, 310, 65!	5 0	2, 310, 655	40. 00
41. 00   04100   SUBPROVI DER	- IRF	6, 846, 801		6, 846, 80°	1 0	6, 846, 801	41.00
43. 00 04300 NURSERY		3, 435, 576		3, 435, 57	6 0	3, 435, 576	43.00
ANCI LLARY SERVI CE							
50.00   05000   OPERATING RO	DOM	14, 396, 212		14, 396, 21:	2 0	14, 396, 212	50.00
50. 01  05001 ENDOSCOPY		3, 714, 577		3, 714, 57		3, 714, 577	50. 01
51.00  05100 RECOVERY ROC	DM	2, 541, 988		2, 541, 98	3 0	2, 541, 988	51.00
52. 00   05200   DELIVERY ROC	OM & LABOR ROOM	5, 334, 075		5, 334, 07	5 0	5, 334, 075	52.00
53. 00   05300   ANESTHESI OLO		0				0	53.00
54. 00   05400   RADI OLOGY-DI		8, 557, 160		8, 557, 160	0	8, 557, 160	54.00
54. 01   05401   RADI OLOGY -		2, 855, 724		2, 855, 72	4 0	2, 855, 724	54. 01
55. 00   05500   RADI OLOGY-TH		3, 371, 913		3, 371, 91	3 0	3, 371, 913	55.00
55. 01  05501  I NFUSI ON CEN		34, 954		34, 95		34, 954	
56. 00   05600   RADI 01 SOTOPE	- -	3, 122, 335		3, 122, 33!		3, 122, 335	56.00
57.00  05700 CT SCAN		4, 734, 529		4, 734, 52		4, 734, 529	57.00
	SONANCE IMAGING (MRI)	1, 915, 406		1, 915, 40		1, 915, 406	
59. 00  05900 CARDI AC CATH	HETERI ZATI ON	5, 816, 777		5, 816, 77		5, 816, 777	
60. 00   06000   LABORATORY		15, 823, 209		15, 823, 20		15, 823, 209	60.00
60. 01   06001   BL00D   LABORA		0				0	60. 01
	LAB SERVICES-PRGM ONLY	0			ار م	0	61.00
	& PACKED RED BLOOD CELLS	2, 102, 016		2, 102, 01		2, 102, 016	
	NG, PROCESSING & TRANS.	0			٦	0	63.00
64. 00   06400   I NTRAVENOUS		0			0	0	64.00
65. 00   06500   RESPI RATORY		5, 333, 702	0	5, 333, 70		5, 333, 702	
66. 00   06600 PHYSI CAL THE		2, 824, 583	0	2, 824, 58		2, 824, 583	66. 00
67. 00  06700 OCCUPATI ONAL		2, 375, 466	0	2, 375, 46		2, 375, 466	
68. 00   06800   SPEECH PATHO		831, 058	0	831, 058		831, 058	
69. 00   06900   ELECTROCARDI		1, 451, 862		1, 451, 86		1, 451, 862	69.00
69. 01   06901   CARDI AC   REHA		646, 798		646, 798		646, 798	1
70. 00 07000 ELECTROENCER		1, 869, 556		1, 869, 55		1, 869, 556	
	PLIES CHARGED TO PATIENTS	17, 295, 205		17, 295, 20		17, 295, 205	
	CHARGED TO PATIENTS	14, 551, 341		14, 551, 34		14, 551, 341	
73. 00 07300 DRUGS CHARGE		26, 233, 870		26, 233, 870		26, 233, 870	
74. 00 07400 RENAL DI ALYS		2, 693, 785		2, 693, 78	5 0	2, 693, 785	74.00
OUTPATIENT SERVICE	E COST CENTERS				. 1		
90. 00   09000   CLI NI C		10, 060, 179		10, 060, 17		10, 060, 179	•
91. 00   09100   EMERGENCY		18, 485, 290		18, 485, 290		18, 485, 290	
	BEDS (NON-DISTINCT PART)	17, 149, 487		17, 149, 48	/	17, 149, 487	92.00
OTHER REI MBURSABLI		0.00/.0=-1		0.00/ ==		0.00/.0=:	101 00
101. 00 10100 HOME HEALTH		3, 396, 871	-	3, 396, 87		3, 396, 871	
	ee instructions)	300, 556, 031	0			300, 568, 508	
201. 00 Less Observa		17, 149, 487	^	17, 149, 48		17, 149, 487	
202.00   Total (see i	nstructions)	283, 406, 544	0	283, 406, 54	4 12, 477	283, 419, 021	J202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES In Lieu of Form CMS-2552-10 METHODIST HOSPITALS, INC Peri od: Worksheet C
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am Provi der CCN: 15-0002 Title XVIII Hospi tal PPS Charges
Inpatient Outpatient Total (col. 6 Cost or Other Cost Center Description TEFRA

	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	74, 729, 498		74, 729, 498			30.00
31.00	03100 INTENSIVE CARE UNIT	17, 300, 097		17, 300, 097			31.00
31. 01	03101 NEONATAL I CU	4, 913, 332		4, 913, 332			31.01
40.00	04000 SUBPROVI DER - I PF	4, 966, 991		4, 966, 991			40.00
41.00	04100 SUBPROVI DER - I RF	7, 194, 491		7, 194, 491			41.00
43.00	04300 NURSERY	2, 277, 786		2, 277, 786			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	74, 739, 176	68, 327, 470			0.000000	50.00
50. 01	05001 ENDOSCOPY	3, 998, 872	14, 869, 548	18, 868, 420	0. 196867	0.000000	50. 01
51.00	05100 RECOVERY ROOM	4, 161, 120	5, 916, 749		0. 252235	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 679, 650	2, 716, 894	4, 396, 544	1. 213243	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	_		0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 128, 744	30, 957, 817	41, 086, 561	0. 208272	0.000000	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	4, 848, 261	13, 628, 220	18, 476, 481		0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 204, 692	19, 639, 802	20, 844, 494	0. 161765	0.000000	55.00
55. 01	05501 I NFUSI ON CENTER	5, 351	227, 017	232, 368		0.000000	55. 01
56.00	05600 RADI OI SOTOPE	5, 581, 302	10, 031, 518	15, 612, 820	0. 199985	0.000000	56.00
57.00	05700 CT SCAN	45, 835, 085	80, 024, 036	125, 859, 121		0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 987, 185	17, 613, 176		0. 062594	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	29, 831, 490	39, 220, 058	69, 051, 548	0. 084238	0.000000	59.00
60.00	06000 LABORATORY	62, 317, 258	93, 907, 055	156, 224, 313		0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 807, 918	2, 208, 492	10, 016, 410	0. 209857	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0		0.000000	
65.00	06500 RESPI RATORY THERAPY	40, 233, 207	5, 131, 331			0.000000	
66.00	06600 PHYSI CAL THERAPY	7, 217, 489	667, 109	7, 884, 598	0. 358241	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	5, 593, 932	396, 708			0.000000	
68.00	06800 SPEECH PATHOLOGY	2, 363, 744	251, 223			0.000000	
69.00	06900 ELECTROCARDI OLOGY	13, 303, 680	12, 387, 949			0.000000	
69. 01	06901 CARDI AC REHAB	250, 163	652, 895			0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	9, 567, 776	16, 618, 709			0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 819, 479	27, 768, 577			0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 922, 656	12, 250, 565		0. 535503	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	99, 304, 196	54, 957, 580			0.000000	73. 00
74.00	07400 RENAL DIALYSIS	7, 615, 815	1, 055, 186	8, 671, 001	0. 310666	0. 000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	515, 789	25, 275, 810			0.000000	
91.00	09100 EMERGENCY	16, 536, 787	56, 755, 752			0.000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 279, 333	25, 074, 849	32, 354, 182	0. 530055	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	3, 536, 512				101.00
200.00		624, 032, 345	642, 068, 607	1, 266, 100, 952			200. 00
201.00	1						201. 00
202 00	Total (see instructions)	624 032 345	642 068 607	1 266 100 952	i l		202 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	Peri od: Worksheet C Part I

				6/25/2020 8:03 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31. 01   03101   NEONATAL   CU				31. 01
40. 00   04000   SUBPROVI DER - I PF				40.00
41. 00   04100   SUBPROVI DER -   I RF				41.00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 100626			50.00
50. 01   05001   ENDOSCOPY	0. 196867			50. 01
51.00   05100   RECOVERY ROOM	0. 252235			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1. 213243			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 208272			54.00
54. 01   05401 RADI OLOGY - ULTRASOUND	0. 154560			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 161765			55.00
55. 01 05501 I NFUSI ON CENTER	0. 150425			55. 01
56. 00   05600   RADI 01 SOTOPE	0. 199985			56.00
57. 00 05700 CT SCAN	0. 037618			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 062594			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 084238			59.00
60. 00 06000 LABORATORY	0. 101285			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 209857			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 117574			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 358241			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 396530			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 317808			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 056511			69.00
69. 01   06901   CARDI AC   REHAB	0. 716231			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 071394			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341883			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 535503			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 170061			73.00
74.00 07400 RENAL DIALYSIS	0. 310666			74.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 390056			90.00
91. 00 09100 EMERGENCY	0. 252212			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530055			92.00
OTHER REIMBURSABLE COST CENTERS				
101. 00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	'			•

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2019	Worksheet C Part I Date/Time Prepared:

					Γο 12/31/2019	Date/Time Pre 6/25/2020 8:0	
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
			<u> </u>		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)	0.00	2.00	4.00	F 00	
LNDATI	ENT DOUTINE CERVICE COST CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
	ENT ROUTINE SERVICE COST CENTERS  ADULTS & PEDIATRICS	73, 514, 433		73, 514, 43	3 12, 477	73, 526, 910	30.00
	INTENSIVE CARE UNIT	12, 306, 663		12, 306, 66		12, 306, 663	
	NEONATAL ICU	2, 621, 975		2, 621, 97	I	2, 621, 975	
1 1	SUBPROVIDER - IPF	2, 310, 655		2, 310, 65		2, 310, 655	
	SUBPROVIDER - IFF	6, 846, 801		6, 846, 80		6, 846, 801	41.00
	NURSERY	3, 435, 576		3, 435, 57		3, 435, 576	
	ARY SERVICE COST CENTERS	3, 433, 370		3, 433, 37	<u> </u>	3, 433, 370	43.00
	OPERATING ROOM	14, 396, 212		14, 396, 21	2 0	14, 396, 212	50.00
	ENDOSCOPY	3, 714, 577		3, 714, 57		3, 714, 577	
	RECOVERY ROOM	2, 541, 988		2, 541, 98		2, 541, 988	
	DELIVERY ROOM & LABOR ROOM	5, 334, 075		5, 334, 07		5, 334, 075	
	ANESTHESI OLOGY	0, 334, 073		3, 334, 07		0, 334, 073	53.00
	RADI OLOGY-DI AGNOSTI C	8, 557, 160		8, 557, 16	٦ - ١	8, 557, 160	1
	RADI OLOGY - ULTRASOUND	2, 855, 724		2, 855, 72		2, 855, 724	
	RADI OLOGY-THERAPEUTI C	3, 371, 913		3, 371, 91	I .	3, 371, 913	
	INFUSION CENTER	34, 954		34, 95		34, 954	
	RADI OI SOTOPE	3, 122, 335		3, 122, 33	I	3, 122, 335	
	CT SCAN	4, 734, 529		4, 734, 52	I	4, 734, 529	
	MAGNETIC RESONANCE IMAGING (MRI)	1, 915, 406		1, 915, 40		1, 915, 406	1
	CARDI AC CATHETERI ZATI ON	5, 816, 777		5, 816, 77	I	5, 816, 777	59.00
	LABORATORY	15, 823, 209		15, 823, 20	I	15, 823, 209	
	BLOOD LABORATORY	0		10,020,20		0	60. 01
	PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 102, 016		2, 102, 01		2, 102, 016	
	BLOOD STORING, PROCESSING & TRANS.	0			ol ol	0	1
	I NTRAVENOUS THERAPY	0				0	64.00
	RESPI RATORY THERAPY	5, 333, 702	0			5, 333, 702	1
	PHYSI CAL THERAPY	2, 824, 583	0			2, 824, 583	
	OCCUPATI ONAL THERAPY	2, 375, 466	l o	2, 375, 46	I .	2, 375, 466	
	SPEECH PATHOLOGY	831, 058	0	831, 05		831, 058	1
	ELECTROCARDI OLOGY	1, 451, 862		1, 451, 86		1, 451, 862	1
	CARDI AC REHAB	646, 798		646, 79	I I	646, 798	
	ELECTROENCEPHALOGRAPHY	1, 869, 556		1, 869, 55		1, 869, 556	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 295, 205		17, 295, 20	I I	17, 295, 205	
	IMPL. DEV. CHARGED TO PATIENTS	14, 551, 341		14, 551, 34		14, 551, 341	
	DRUGS CHARGED TO PATIENTS	26, 233, 870		26, 233, 87		26, 233, 870	
	RENAL DIALYSIS	2, 693, 785		2, 693, 78	I I	2, 693, 785	
	TENT SERVICE COST CENTERS	,		,	- 1	, , , , , , , , , , , , , , , , , , , ,	
90.00 09000 0		10, 060, 179		10, 060, 17	9 0	10, 060, 179	90.00
	EMERGENCY	18, 485, 290		18, 485, 29	I .	18, 485, 290	
	OBSERVATION BEDS (NON-DISTINCT PART)	17, 149, 487		17, 149, 48	I	17, 149, 487	
	REIMBURSABLE COST CENTERS				· '		1
101. 00 10100 F	HOME HEALTH AGENCY	3, 396, 871		3, 396, 87	1	3, 396, 871	101.00
200.00	Subtotal (see instructions)	300, 556, 031	0	300, 556, 03	1 12, 477	300, 568, 508	200.00
201. 00 I	Less Observation Beds	17, 149, 487		17, 149, 48	7	17, 149, 487	201.00
202. 00	Total (see instructions)	283, 406, 544	0	283, 406, 54	12, 477	283, 419, 021	202.00
					,		

From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/25/2020 8:03 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 74, 729, 498 30.00 03000 ADULTS & PEDIATRICS 74, 729, 498 30.00 31.00 03100 INTENSIVE CARE UNIT 17, 300, 097 17, 300, 097 31.00 4, 913, 332 4, 913, 332 03101 NEONATAL ICU 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 4, 966, 991 4, 966, 991 40.00 04100 SUBPROVI DER - I RF 41.00 7, 194, 491 7, 194, 491 41.00 43.00 04300 NURSERY 2, 277, 786 2, 277, 786 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 74, 739, 176 50.00 68, 327, 470 143, 066, 646 0.100626 0.000000 50.00 05001 ENDOSCOPY 50.01 3, 998, 872 14, 869, 548 18, 868, 420 0.196867 0.000000 50.01 51.00 05100 RECOVERY ROOM 4, 161, 120 5, 916, 749 10, 077, 869 0.252235 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 679, 650 2, 716, 894 4, 396, 544 1. 213243 0.000000 52.00 05300 ANESTHESI OLOGY 53 00 0.000000 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 128, 744 30, 957, 817 41, 086, 561 0.208272 0.000000 54.00 18, 476, 481 54 01 05401 RADI OLOGY - ULTRASOUND 4, 848, 261 13, 628, 220 0.154560 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 19, 639, 802 20, 844, 494 55.00 1, 204, 692 0.161765 0.000000 55.00 05501 INFUSION CENTER 232, 368 55.01 5.351 227, 017 0.150425 0.000000 55 01 05600 RADI OI SOTOPE 5, 581, 302 10, 031, 518 15, 612, 820 0. 199985 0.000000 56.00 56.00 57.00 05700 CT SCAN 45, 835, 085 80, 024, 036 125, 859, 121 0.037618 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 12, 987, 185 58.00 17, 613, 176 30, 600, 361 0.062594 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 29, 831, 490 39, 220, 058 69, 051, 548 0.084238 0.000000 59.00 60.00 06000 LABORATORY 62, 317, 258 93, 907, 055 156, 224, 313 0.101285 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 807, 918 2, 208, 492 10, 016, 410 0.209857 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0.000000 63.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 40, 233, 207 45, 364, 538 65.00 5, 131, 331 0.117574 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 7, 217, 489 667, 109 7, 884, 598 0.358241 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 5, 990, 640 67.00 5, 593, 932 396, 708 0.396530 0.000000 67.00 68 00 06800 SPEECH PATHOLOGY 2 363 744 251 223 2 614 967 0.317808 0.000000 68 00 06900 ELECTROCARDI OLOGY 69.00 13, 303, 680 12, 387, 949 25, 691, 629 0.056511 0.000000 69.00 06901 CARDI AC REHAB 250, 163 652, 895 903, 058 0.716231 0.000000 69.01 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 9, 567, 776 16, 618, 709 26, 186, 485 0.071394 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 50, 588, 056 0.000000 71 00 22, 819, 479 27, 768, 577 0.341883 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 922, 656 12, 250, 565 27, 173, 221 0.535503 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 99, 304, 196 54, 957, 580 154, 261, 776 0.170061 0.000000 73.00 73.00 1, 055, 186 74 00 07400 RENAL DIALYSIS 7, 615, 815 8, 671, 001 0.310666 0.000000 74 00 OUTPATIENT SERVICE COST CENTERS 25, 275, 810 90.00 09000 CLI NI C 515, 789 25, 791, 599 0.390056 0.000000 90.00 91.00 09100 EMERGENCY 16, 536, 787 56, 755, 752 73, 292, 539 0.252212 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 25, 074, 849 0.530055 0.000000 92 00 7, 279, 333 32, 354, 182 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 536, 512 3, 536, 512 101.00 200.00 Subtotal (see instructions) 642, 068, 607 1, 266, 100, 952 200.00 624, 032, 345

624, 032, 345

642, 068, 607 1, 266, 100, 952

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form	CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2019 Part I To 12/31/2019 Date/Tim	-

					6/25/2020 8:03 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.0
31.00	03100 INTENSIVE CARE UNIT				31.0
31.01	03101 NEONATAL I CU				31.0
40.00	04000 SUBPROVI DER - I PF				40.0
41.00	04100 SUBPROVI DER - I RF				41.0
43.00	04300 NURSERY				43.0
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50. C
50. 01	05001 ENDOSCOPY	0. 000000			50. C
51.00	05100 RECOVERY ROOM	0. 000000			51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53.00	05300 ANESTHESI OLOGY	0. 000000			53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
54.01	05401 RADI OLOGY - ULTRASOUND	0. 000000			54.0
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. C
55. 01	05501 INFUSION CENTER	0. 000000			55. C
56.00	05600 RADI 0I S0T0PE	0. 000000			56.0
	05700 CT SCAN	0. 000000			57. C
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.0
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
	06000 LABORATORY	0. 000000			60.0
	06001 BLOOD LABORATORY	0. 000000			60.0
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
	06400 I NTRAVENOUS THERAPY	0. 000000			64.0
	06500 RESPI RATORY THERAPY	0. 000000			65.0
	06600 PHYSI CAL THERAPY	0. 000000			66.0
	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
	06800 SPEECH PATHOLOGY	0. 000000			68.0
	06900 ELECTROCARDI OLOGY	0. 000000			69.0
	06901 CARDI AC REHAB	0. 000000			69.0
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
	07400 RENAL DI ALYSI S	0. 000000			74.0
7 1. 00	OUTPATIENT SERVICE COST CENTERS	0. 000000			, 1. 6
90.00	09000 CLINIC	0. 000000			90.0
	09100 EMERGENCY	0. 000000			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0
72.00	OTHER REIMBURSABLE COST CENTERS	0.000000			72.0
101 00	10100 HOME HEALTH AGENCY				101.0
200.00	l				200. 0
201.00					201.0
202.00	l				202. 0
202.00	1.3441 (300 111341 4041 0113)	1			1202.0

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00 ADULTS & PEDIATRICS	6, 836, 028		-,,			1
31.00 INTENSIVE CARE UNIT	512, 154		512, 15			
31. 01 NEONATAL I CU	64, 448		64, 44			
40. 00   SUBPROVI DER - I PF	103, 008		103, 00			
41. 00 SUBPROVI DER - I RF	688, 800	l e	688, 80			
43. 00 NURSERY	479, 415	l e	479, 41			1
200.00 Total (lines 30 through 199)	8, 683, 853		8, 683, 85	3 107, 983		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	22, 149				l	30.00
31. 00   INTENSIVE CARE UNIT	4, 320		•		l	31.00
31. 01 NEONATAL I CU	0	1			l	31. 01
40. 00 SUBPROVI DER - I PF	1, 363				l	40.00
41. 00 SUBPROVI DER - I RF	4, 740	l .	•		ļ	41.00
43. 00 NURSERY	0	1			ļ	43.00
200.00 Total (lines 30 through 199)	32, 572	2, 544, 329	l			200. 00

Health Financial Systems	METHODIST HOS			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/25/2020 8:0	pared: 3 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	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	1, 316, 948	143, 066, 646			206, 035	50.00
50. 01   05001   ENDOSCOPY	45, 796				3, 753	50. 01
51.00   05100   RECOVERY ROOM	292, 302	10, 077, 869	0.02900	4 1, 346, 196	39, 045	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	192, 368	4, 396, 544	0.04375		1, 258	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 057, 125	41, 086, 561	0. 02572	9 4, 304, 967	110, 762	54.00
54. 01   05401 RADI OLOGY - ULTRASOUND	123, 931	18, 476, 481	0.00670	8 1, 634, 949	10, 967	54.01
55. 00   05500 RADI OLOGY-THERAPEUTI C	278, 933	20, 844, 494	0. 01338	2 409, 243	5, 476	55.00
55. 01   05501   INFUSION CENTER	6, 922	232, 368	0. 02978	9 0	0	55. 01
56. 00   05600   RADI 01 SOTOPE	195, 610	15, 612, 820	0. 01252	9 2, 230, 007	27, 940	56.00
57. 00   05700   CT   SCAN	263, 761	125, 859, 121	0.00209	6 17, 838, 425	37, 389	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 222	30, 600, 361	0.00350	4, 845, 029	16, 977	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	237, 897	69, 051, 548	0.00344	5 10, 210, 786	35, 176	59.00
60. 00 06000 LABORATORY	645, 009	156, 224, 313	0.00412	9 21, 630, 168	89, 311	60.00
60. 01 06001 BLOOD LABORATORY	0				0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	29, 692	10, 016, 410	0. 00296	4 3, 597, 929	10, 664	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	207, 786	45, 364, 538	0.00458	0 14, 113, 407	64, 639	65.00
66. 00 06600 PHYSI CAL THERAPY	246, 549		0. 03127		53, 418	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	211, 706	5, 990, 640	0. 03533	9 1, 094, 240	38, 669	67.00
68. 00 06800 SPEECH PATHOLOGY	39, 637				13, 429	68.00
69. 00 06900 ELECTROCARDI OLOGY	25, 404				5, 718	69.00
69. 01 06901 CARDI AC REHAB	4, 829				2	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	28, 189		0. 00107	6 2, 950, 616	3, 175	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496, 183				82, 583	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	412, 653				82, 515	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	558, 553					73.00
74. 00   07400   RENAL DI ALYSI S	101, 944		0. 01175			74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1, 477, 327	25, 791, 599	0. 05727	9 137, 234	7, 861	90.00
91. 00   09100   EMERGENCY	744, 981					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 594, 439	1 ' '			170, 122	92.00
200.00 Total (lines 50 through 199)		1, 151, 182, 245		179, 773, 906		
1.2.2. (	1	, , ,	1		., , 0 . 0	, , , , , ,

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2019 To 12/31/2019		epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	31. 00 31. 01 40. 00 41. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days 6.00	-	Inpatient Program Days	200.00
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00	0 0	0 0 0 0 0	7, 57 2, 21 3, 01 7, 78 2, 63	74     0.00       3     0.00       6     0.00       66     0.00       62     0.00	4, 320 0 1, 363 4, 740 0	31. 00 31. 01 40. 00 41. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0	107, 90	<u></u>	32, 372	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	000000000000000000000000000000000000000					30. 00 31. 00 31. 01 40. 00 41. 00 43. 00 200. 00
200.00 Total (lines 30 through 199)	0					1200 0

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0002	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	Part IV

Tilloudi 30313				То	12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Title	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	I	Allied Health	Allied Health	
	Anesthetist	School	School	F	Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
		Adjustments					
	1. 00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50.00   05000   OPERATING ROOM	0	0		0	0	0	50.00
50. 01   05001   ENDOSCOPY	0	0		0	0	0	50. 01
51.00  05100   RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01   05401   RADI OLOGY - ULTRASOUND	0	0		0	0	0	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01   05501   I NFUSI ON CENTER	0	0		0	0	0	55. 01
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	0	56. 00
57.00  05700   CT SCAN	0	0		0	0	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60. 00   06000   LABORATORY	0	0		0	0	0	60.00
60. 01   06001   BLOOD LABORATORY	0	0		0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
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
69. 01   06901   CARDI AC   REHAB	0	0		0	o	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
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	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	o	0	73.00
74. 00   07400   RENAL DI ALYSI S	0	0		0	o	0	74.00
OUTPATIENT SERVICE COST CENTERS				•			
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	0		0	o	1, 069, 309	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
200.00   Total (lines 50 through 199)	0	0		0	o	1, 069, 309	200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0002	Peri od: Worksheet D

From 01/01/2019 Part IV To 12/31/2019 Date/Time Prepared: THROUGH COSTS 6/25/2020 8:03 am Title XVIII Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost 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 0 143, 066, 646 0.000000 50.00 05001 ENDOSCOPY 0 0 18, 868, 420 0.000000 50.01 000000000000000 50.01 05100 RECOVERY ROOM 10, 077, 869 0 51.00 0 0.000000 51.00 οĺ 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4, 396, 544 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 41, 086, 561 0.000000 54.00 54.01 05401 RADI OLOGY - ULTRASOUND 0 0 18, 476, 481 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0 20, 844, 494 0.000000 55.00 55.01 05501 INFUSION CENTER 232, 368 0.000000 55.01 05600 RADI OI SOTOPE 0 0.000000 56.00 15, 612, 820 56.00 05700 CT SCAN 0 125, 859, 121 0.000000 57.00 C 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 30, 600, 361 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 69, 051, 548 59.00 0 0.000000 59.00 06000 LABORATORY 0 60 00 0 156, 224, 313 0 000000 60 00 0 60.01 06001 BLOOD LABORATORY 0 0.000000 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0000000000000 10, 016, 410 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 O 0.000000 63 00 63 00 0 64.00 06400 I NTRAVENOUS THERAPY 0 0.000000 64.00 06500 RESPIRATORY THERAPY 45, 364, 538 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 7, 884, 598 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0 0 5, 990, 640 0 000000 67.00 67 00 68.00 06800 SPEECH PATHOLOGY 2, 614, 967 0.000000 68.00 06900 ELECTROCARDI OLOGY 25, 691, 629 0.000000 69.00 69.00 06901 CARDI AC REHAB 903, 058 0.000000 69.01 69.01 0 0 07000 ELECTROENCEPHALOGRAPHY 0 26, 186, 485 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 50, 588, 056 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 27, 173, 221 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 Ω 0.000000 154, 261, 776 74.00 07400 RENAL DIALYSIS 8, 671, 001 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 25, 791, 599 0.000000 90.00 0.014590 91. 00 09100 EMERGENCY 1,069,309 1, 069, 309 73, 292, 539 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 32, 354, 182 0.000000 92.00

1, 069, 309

1, 069, 309

1, 151, 182, 245

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider	: Worksheet D 1/01/2019 Part IV 2/31/2019 Date/Time Prepared:

THROUG	H CUSTS				To 12/31/2019	Date/Time Pre 6/25/2020 8:0	pared: 3 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		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	22, 382, 919		0 17, 967, 859		
50. 01	05001  ENDOSCOPY	0. 000000	1, 546, 537		0 3, 659, 444		50. 01
51.00	05100  RECOVERY ROOM	0. 000000	1, 346, 196	l .	0 1, 776, 009	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	28, 747		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	4, 304, 967		0 5, 431, 282		54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0. 000000	1, 634, 949		0 1, 709, 883		54. 01
55.00	05500   RADI OLOGY-THERAPEUTI C	0. 000000	409, 243		0 6, 807, 240	0	55.00
55. 01	05501   I NFUSI ON CENTER	0. 000000	0		0 2	0	55. 01
56.00	05600 RADI OI SOTOPE	0. 000000	2, 230, 007		0 2, 709, 860	0	56.00
57.00	05700 CT SCAN	0. 000000	17, 838, 425		0 16, 928, 260	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	4, 845, 029		0 4, 128, 721	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	10, 210, 786		0 13, 713, 379	0	59.00
60.00	06000 LABORATORY	0. 000000	21, 630, 168		0 7, 710, 770	0	60.00
60.01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	3, 597, 929		0 328, 331	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	14, 113, 407		0 874, 952	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 708, 279		0 3, 518	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 094, 240		0 6, 044	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	885, 957		0 36, 842	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	5, 782, 054		0 3, 148, 682	0	69.00
69. 01	06901 CARDI AC REHAB	0. 000000	283		0 176, 361	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 950, 616		0 4, 347, 208	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	8, 419, 923		0 6, 878, 081	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 433, 633		0 3, 773, 954	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	33, 883, 399		0 15, 821, 998	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 000000	3, 498, 938		0 486, 001	0	74.00
	OUTPATIENT SERVICE COST CENTERS	•					
90.00	09000 CLI NI C	0. 000000	137, 234		0 5, 206, 788	0	90.00
91.00	09100 EMERGENCY	0. 014590	6, 407, 953				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 452, 088		0 3, 726, 428		92.00
200.00			179, 773, 906				200. 00

Hearth Financial Systems	METHODIST HOS	PLIALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/25/2020 8:0	
-		Title	XVIII	Hospi tal	PPS	<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		Services Not	(333 11121)	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	<u> </u>	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. 100626	17, 967, 859		0 0	1, 808, 034	50.00
50. 01   05001 ENDOSCOPY	0. 196867	3, 659, 444		0	720, 424	50. 01
51.00   O5100   RECOVERY ROOM	0. 252235	1, 776, 009	)	0	447, 972	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 213243	0		0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 208272	5, 431, 282	2	0	1, 131, 184	54.00
54. 01   05401 RADI OLOGY - ULTRASOUND	0. 154560	1, 709, 883	:	0	264, 280	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 161765	6, 807, 240		0	1, 101, 173	55.00
55. 01   05501   I NFUSI ON CENTER	0. 150425	2		0 0	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0. 199985	2, 709, 860		0 0	541, 931	56.00
57. 00 05700 CT SCAN	0. 037618	16, 928, 260		0 0	636, 807	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 062594	4, 128, 721		0 0	258, 433	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 084238	13, 713, 379	•	0 0	1, 155, 188	59.00
60. 00 06000 LABORATORY	0. 101285			0 0	780, 985	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 209857	328, 331		0 0	68, 903	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		1	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	l 0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 117574	874, 952		0 0	102, 872	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 358241	3, 518	1	0 0	1, 260	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 396530		1	0 0	2, 397	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 317808	36, 842		0 0	11, 709	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 056511	3, 148, 682		0 0	177, 935	69.00
69. 01 06901 CARDI AC REHAB	0. 716231	176, 361		0 0	126, 315	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 071394		•	0 0	310, 365	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341883		1	o o	2, 351, 499	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 535503			0	2, 020, 964	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 170061	15, 821, 998	•	0 46, 691	2, 690, 705	73.00
74. 00   07400   RENAL DI ALYSI S	0. 310666		1	0 0	150, 984	74.00
OUTPATIENT SERVICE COST CENTERS				-1	1227121	
90. 00 09000 CLI NI C	0. 390056	5, 206, 788		0 0	2, 030, 939	90.00
91. 00 09100 EMERGENCY	0. 252212		•	0 124	1, 757, 632	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530055			0 0	1, 975, 212	92.00
200.00 Subtotal (see instructions)		134, 326, 766		0 46, 815	22, 626, 102	•
201.00 Less PBP Clinic Lab. Services-Program		121,020,700		0 .3,310	, 525, .02	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		134, 326, 766		0 46, 815	22, 626, 102	202. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002	Peri od: Worksheet D From 01/01/2019 Part V

				To 12/31/2019	Date/Time Pro 6/25/2020 8:0	
		Title	XVIII	Hospi tal	PPS	<u> </u>
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0				50.00
50. 01  05001   ENDOSCOPY	0	0				50. 01
51.00  05100   RECOVERY ROOM	0	0				51.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01  05401   RADI OLOGY - ULTRASOUND	0	0				54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0				55. 00
55. 01  05501   I NFUSI ON CENTER	0	0				55. 01
56. 00   05600   RADI 0I SOTOPE	0	0				56. 00
57. 00  05700   CT   SCAN	0	0	1			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	1			59.00
60. 00  06000  LABORATORY	0	0				60.00
60. 01   06001   BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1			63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	1			64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00   06600   PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00   06800   SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01   06901   CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7, 940	1			73.00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS	_	_				100.00
90. 00   09000   CLI NI C	0	0	1			90.00
91. 00   09100   EMERGENCY	0	31				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		7 071				92.00
200.00 Subtotal (see instructions)		7, 971				200.00
201.00 Less PBP Clinic Lab. Services-Program						201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	7, 971				202. 00
202.00   Net onalyes (THE 200 - THE 201)	1	1,7/1	I			1202.00

Health Financial Systems	METHODIST HOS	SPITALS. INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15-0002 CCN: 15-S002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D	
		·			6/25/2020 8:0	3 am
		Titl∈	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	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)	0.00	0.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM	1, 316, 948	143, 066, 646	0.00920	)5 0	0	50.00
50. 01   05000   OPERATING ROOM 50. 01   05001   ENDOSCOPY	1, 316, 948		l .		0	50.00
51. 00   05100   RECOVERY ROOM	292, 302				0	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	192, 368				0	52.00
53. 00   05300   ANESTHESI OLOGY	192, 300				0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	1, 057, 125	-	1		506	
54. 01   05401   RADI OLOGY - ULTRASOUND	123, 931				87	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	278, 933				0	
55. 01   05501   NFUSI ON CENTER	6, 922		l .		0	
56. 00   05600 RADI OI SOTOPE	195, 610		l .		26	
57. 00 05700 CT SCAN	263, 761				118	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 222				76	
59. 00 05900 CARDI AC CATHETERI ZATI ON	237, 897				41	59.00
60. 00   06000   LABORATORY	645, 009				828	
60. 01   06001   BLOOD LABORATORY	0		l .		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	29, 692	10, 016, 410	0.00296	16, 696	49	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		1		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 00000	oo o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	207, 786	45, 364, 538	0. 00458	4, 233	19	65.00
66. 00   06600 PHYSI CAL THERAPY	246, 549	7, 884, 598			91	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	211, 706	5, 990, 640	0. 03533	1, 448	51	67.00
68. 00 06800 SPEECH PATHOLOGY	39, 637				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	25, 404				47	69. 00
69. 01   06901   CARDI AC REHAB	4, 829				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	28, 189		l .		2	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496, 183		1		92	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	412, 653		l .		30	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	558, 553				1, 954	
74. 00 07400 RENAL DIALYSIS	101, 944	8, 671, 001	0. 01175	57 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	4 477 007	25 701 500	0.0570	70		00.00
90. 00 09000 CLINIC	1, 477, 327				0	
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	744, 981		l .		366	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (lines 50 through 199)	0 240 257	32, 354, 182 1, 151, 182, 245		987, 132	4 292	92. 00 200. 00
200.00   Total (Titles 30 till bugit 199)	7, 347, 257	1, 151, 162, 245	I	901, 132	4, 383	<sub>1</sub> 200.00

	Financial Systems	METHODIST HOS			1-		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0002		i od: om 01/01/2019	Worksheet D Part IV	
THROUG	H COSTS		Component	CCN: 15-S002	To	12/31/2019		pared: 3 am
			Title	XVIII	Su	ubprovi der  - I PF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Α		Allied Health	
		Anestheti st	School	School		ost-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
	ANOLULARY OFRICAS COOT OFFITERS	1. 00	2A	2. 00		3A	3. 00	
F0 00	ANCILLARY SERVICE COST CENTERS					ما		F0 00
50.00	05000 OPERATING ROOM	0	_		0	0	0	50.00
50. 01	05001   ENDOSCOPY   05100   RECOVERY   ROOM	0	0		0	0	0	50.01
51.00		0	0		-	0	-	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	O O	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0		0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01	05501 I NFUSI ON CENTER	0	0		0	0	0	55.01
56. 00	05600 RADI OI SOTOPE	0	0		0	o	0	56.00
57.00	05700 CT SCAN	0	0		0	O	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	o	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
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
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	ol Ol	0	69.00
	06901 CARDI AC REHAB		0		0	0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	n		0	o o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	l ő	n		0	o	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	o	0	73.00
74. 00	07400 RENAL DIALYSIS	o	Ö		Ö	Ö	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	90.00
91 00	09100 EMERGENCY	0	0	1	0	ol	1.069.309	01 00

0 0 0

0

0

1, 069, 309 91. 00 0 92. 00 1, 069, 309 200. 00

91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

IPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PAS		CN: 15-0002 CCN: 15-S002	Peri od: From 01/01/2019 To 12/31/2019		pared: 3 am
		Title	× XVIII	Subprovi der  - I PF	PPS	
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		(col. 5 ÷	
	Cost	4)	cols. 2, 3, and 4)	col . 8)	col. 7)	
			and 4)		(see instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
0. 00 05000 OPERATING ROOM	0	0		0 143, 066, 646	0.000000	50.00
60. 01   05001 ENDOSCOPY	0	0		0 18, 868, 420	0.000000	50.0
1.00 05100 RECOVERY ROOM	0	0		0 10, 077, 869		51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 396, 544	0.000000	
3. 00   05300   ANESTHESI OLOGY	0	0	1	0	0.000000	53.0
64. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1	0 41, 086, 561	0.000000	
64. 01   05401   RADI OLOGY - ULTRASOUND	0		1	0 18, 476, 481	0.000000	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0		1	0 20, 844, 494		
5. 01   05501   I NFUSI ON CENTER	0		1	0 232, 368		
66. 00   05600   RADI OI SOTOPE	0			0 15, 612, 820		•
57. 00   05700   CT SCAN	0 0		1	0 125, 859, 121	0.000000	
8.00   05800   MAGNETI C RESONANCE I MAGING (MRI) 9.00   05900   CARDIAC CATHETERIZATION	0			0 30, 600, 361 0 69, 051, 548	0. 000000 0. 000000	
0.00   06000   LABORATORY				0 156, 224, 313		
0. 01   06001   BLOOD LABORATORY			1	0 130, 224, 313		
11.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ĭ			0.00000	61.0
22.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 10, 016, 410	0. 000000	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		,	0 0		
4. 00 06400 I NTRAVENOUS THERAPY	0	0	j	0 0	0.000000	
5. 00 06500 RESPIRATORY THERAPY	0	0	)	0 45, 364, 538	0.000000	65.0
6. 00 06600 PHYSI CAL THERAPY	0	0	)	0 7, 884, 598	0.000000	66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 990, 640	0.000000	67.0
8. 00 06800 SPEECH PATHOLOGY	0			0 2, 614, 967	0.000000	
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 25, 691, 629		
9. 01   06901   CARDI AC   REHAB	0			0 903, 058		
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 26, 186, 485		
11. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 50, 588, 056		
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 27, 173, 221	0.000000	
'3.00   07300   DRUGS CHARGED TO PATIENTS '4.00   07400   RENAL DIALYSIS	0 0		l .	0 154, 261, 776 0 8, 671, 001	0. 000000 0. 000000	
OUTPATIENT SERVICE COST CENTERS				0 8, 671, 001	0.000000	1 /4.0
0. 00   09000   CLINIC	0	0		0 25, 791, 599	0. 000000	90.0
11. 00 09100 EMERGENCY	0		1			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o o		1,007,00	0 32, 354, 182		
200.00 Total (lines 50 through 199)	0		1 040 20	09 1, 151, 182, 245		200.0

Health Fin	nancial Systems	METHODIST HOSPI	TAIS INC		Inlie	u of Form CMS-:	2552_10
	MENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der C	CN: 15-0002	Peri od:	Worksheet D	2332 10
THROUGH CO		KVI OE OTHEK TAGO	Trovider o	014. 10 0002	From 01/01/2019	Part IV	
			·	CCN: 15-S002	To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
				XVIII	Subprovi der - I PF	PPS	
	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	Costs (col. 9	
		col. 7) 9.00	10.00	x col. 10)	12.00	x col . 12)	
ANC	LILADY CEDVICE COCT CENTERS	9.00	10. 00	11.00	12.00	13. 00	
	ILLARY SERVICE COST CENTERS OO OPERATING ROOM	0. 000000	0		0 0	0	50.00
	01 ENDOSCOPY	0. 000000	0	l .	0 0	0	
	OO RECOVERY ROOM	0. 000000	0		0 0	0	
	OO DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	
	OO ANESTHESI OLOGY	0. 000000	0		0 0	0	
	OO RADI OLOGY-DI AGNOSTI C	0. 000000	19, 661		0 0	0	
	01 RADI OLOGY - ULTRASOUND	0. 000000	12, 946	•	0 0	0	
	OO RADI OLOGY-THERAPEUTI C	0.000000	12, 740		0 0	0	
	01 I NFUSI ON CENTER	0. 000000	0		0 0	0	
	OO RADI OI SOTOPE	0. 000000	2, 083		0 0	0	
1	OO CT SCAN	0.000000	56, 361		0 0	0	
	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	21, 601		0 0	0	
	OO CARDI AC CATHETERI ZATI ON	0. 000000	12, 023		0 0	0	
	OO LABORATORY	0. 000000	200, 627		0 0	0	
	01 BLOOD LABORATORY	0. 000000	0		0 0	0	
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	Ü			Ü	61.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	16, 696		0	0	1
	00 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
	OO I NTRAVENOUS THERAPY	0. 000000	0	•	0 0	0	
	00 RESPI RATORY THERAPY	0. 000000	4, 233		0	0	
	00 PHYSI CAL THERAPY	0. 000000	2, 902		0 0	0	
	OO OCCUPATI ONAL THERAPY	0. 000000	1, 448		0 0	0	67.00
68.00 0680	OO SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
	00 ELECTROCARDI OLOGY	0. 000000	47, 368		0 0	0	69.00
69. 01 0690	01 CARDI AC REHAB	0. 000000	0		0 0	0	69. 01
70.00 0700	OO ELECTROENCEPHALOGRAPHY	0. 000000	2, 085		0 0	0	70.00
	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	9, 395	•	0 0	0	
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 986		0 0	0	72.00
73.00 0730	OO DRUGS CHARGED TO PATIENTS	0. 000000	539, 721		0 0	0	73.00
	00 RENAL DIALYSIS	0. 000000	0		0	0	74.00
	PATIENT SERVICE COST CENTERS	•					
	OO CLI NI C	0. 000000	0		0 0	0	90.00
91.00 0910	OO EMERGENCY	0. 014590	35, 996	52	25 0	0	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	[	ol o	0	92.00
92. 00 0920 200. 00	OO OBSERVATION BEBS (NON BISTING I TAKI)	0. 000000	O	52			200.00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15-0002 CCN: 15-T002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D	
		Component	CCN. 13-1002		Date/Time Pre 6/25/2020 8:0	3 am
		Title	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	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)	0.00		4.00	5.00	
ANCILLARY CERVICE COCT CENTERC	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	1, 316, 948	143, 066, 646	0.00920	05 196, 667	1, 810	50.00
50. 01   05000   OPERATING ROOM 50. 01   05001   ENDOSCOPY	1, 316, 948		l .		1,810	50.00
51. 00   05100   RECOVERY ROOM	292, 302		0.00242		370	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	192, 368				0	52.00
53. 00   05300   ANESTHESI OLOGY	192, 300				0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	1, 057, 125		1		2, 995	1
54. 01   05401   RADI OLOGY - ULTRASOUND	123, 931		l .		164	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	278, 933				607	55.00
55. 01   05501   NFUSI ON CENTER	6, 922				0.07	55.00
56. 00   05600 RADI OI SOTOPE	195, 610		l .		322	56.00
57. 00 05700 CT SCAN	263, 761				745	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 222				445	
59. 00 05900 CARDI AC CATHETERI ZATI ON	237, 897				235	
60. 00   06000   LABORATORY	645, 009				3, 557	60.00
60. 01   06001   BLOOD LABORATORY	0		l .		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	29, 692	10, 016, 410	0.00296	37, 639	112	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		1		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 00000	00	0	64.00
65. 00 06500 RESPIRATORY THERAPY	207, 786	45, 364, 538	0. 00458	715, 398	3, 277	65.00
66. 00   06600 PHYSI CAL THERAPY	246, 549				65, 056	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	211, 706	5, 990, 640	0. 03533	1, 875, 519	66, 279	67.00
68. 00 06800 SPEECH PATHOLOGY	39, 637				3, 966	
69. 00 06900 ELECTROCARDI OLOGY	25, 404				40	
69. 01   06901   CARDI AC   REHAB	4, 829				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	28, 189		l .		17	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496, 183				1, 450	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	412, 653		l .		988	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	558, 553				9, 678	
74. 00 07400 RENAL DIALYSIS	101, 944	8, 671, 001	0. 01175	335, 576	3, 945	74.00
OUTPATIENT SERVICE COST CENTERS	4 477 007	25 704 500	0.0570	70 704	4.4	00.00
90. 00 09000 CLINIC	1, 477, 327				41	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	744, 981		l .		123	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (lines 50 through 199)	0 240 257	32, 354, 182 1, 151, 182, 245		10, 106, 293	0 166, 250	92.00
200.00   Total (Titles 30 till bugit 199)	7, 347, 257	1, 101, 102, 240	I	10, 100, 293	100, 250	<sub> </sub> 200.00

	Financial Systems	METHODIST HOS			-		of Form CMS-2	<u> 2552-10</u>
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0002		iod: m 01/01/2019	Worksheet D Part IV	
THROUG	GH COSTS		Component	CCN: 15-T002	To	12/31/2019	Date/Time Pre 6/25/2020 8:0	pared: 3 am
			Title	XVIII	Su	bprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		lied Health	Allied Health	
		Anesthetist	School	School		ost-Stepdown		
		Cost	Post-Stepdown		1	Adjustments		
			Adjustments					
	TANGLEL ARV. OFRIG. COOT. OFFITERS	1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
50. 01	05001 ENDOSCOPY	0	0		0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0		0	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01	05501   NFUSI ON CENTER	0	0		0	U	0	55. 01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0		-	0	-	56. 00 57. 00
		0	0		0	0	0	58.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 00	06000 LABORATORY	0	0		0	0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U U	U		U	٩	U	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
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
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
	06901 CARDI AC REHAB	0	0		0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	ol Ol	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		o	o o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	l ol	0		0	n	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	n	0		0	o	0	73.00
74.00	07400 RENAL DIALYSIS	Ö	0		o	Ö	0	74.00
50	OUTPATIENT SERVICE COST CENTERS	<u> </u>				<u> </u>		
90.00	09000 CLI NI C	0	0		0	0	0	90.00
	09100 EMERGENCY	0	0		0	o	1. 069. 309	

0 0 0

0

0

1, 069, 309 91. 00 0 92. 00 1, 069, 309 200. 00

91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

Medical Education Cost	Title  Total Cost  um of cols. 2, 3, and 4)  5.00	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Subprovider - IRF  Total Charges (from Wkst. C, Part I, col. 8)	to Charges	
Medical Education Cost	um of cols. 2, 3, and 4) 5.00	Outpatient Cost (sum of cols. 2, 3,	Total Charges (from Wkst. C, Part I,	to Charges	
ANCILLARY SERVICE COST CENTERS	2, 3, and 4) 5.00	Cost (sum of cols. 2, 3,	C, Part I,		
ANCI LLARY SERVICE COST CENTERS	5. 00	col s. 2, 3,			
ANCILLARY SERVICE COST CENTERS	5.00		( COL. 8)	(col. 5 ÷	
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   0FERATI NG ROOM   0   05001   ENDOSCOPY   0   0   05100   RECOVERY ROOM   0   05100   RECOVERY ROOM   0   05200   05100   RECOVERY ROOM   0   05300   ANESTHESI OLOGY   0   0   05400   ANESTHESI OLOGY   0   0   05400   RADI OLOGY-DI AGNOSTI C   0   05401   RADI OLOGY - ULTRASOUND   0   05500   RADI OLOGY-THERAPEUTI C   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05600   RADI OLOGY-THERAPEUTI C   0   05700   CT SCAN   0   05700   CT SCAN   0   05700   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   06001   BLOOD LABORATORY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   06400   INTRAVENOUS THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   06500   RESPI RATORY THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06600   PHERAPI   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06900   ELECTROCARDI OLOGY   0   06900   06900   ELECTROCARDI OLOGY   0   06900   06900   06900   0CCUPATI ONAL THERAPY   0   06700   0000   0000   0000   0000   0000   0000   00000   00000   00000   00000   00000   000000		anu 4)	,	col. 7) (see	
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   0FERATI NG ROOM   0   05001   ENDOSCOPY   0   0   05100   RECOVERY ROOM   0   05100   RECOVERY ROOM   0   05200   05100   RECOVERY ROOM   0   05300   ANESTHESI OLOGY   0   0   05400   ANESTHESI OLOGY   0   0   05400   RADI OLOGY-DI AGNOSTI C   0   05401   RADI OLOGY - ULTRASOUND   0   05500   RADI OLOGY-THERAPEUTI C   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05600   RADI OLOGY-THERAPEUTI C   0   05700   CT SCAN   0   05700   CT SCAN   0   05700   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   06001   BLOOD LABORATORY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   06400   INTRAVENOUS THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   06500   RESPI RATORY THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06600   PHERAPI   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06900   ELECTROCARDI OLOGY   0   06900   06900   ELECTROCARDI OLOGY   0   06900   06900   06900   0CCUPATI ONAL THERAPY   0   06700   0000   0000   0000   0000   0000   0000   00000   00000   00000   00000   00000   000000				instructions)	
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   0FERATI NG ROOM   0   05001   ENDOSCOPY   0   0   05100   RECOVERY ROOM   0   05100   RECOVERY ROOM   0   05200   05100   RECOVERY ROOM   0   05300   ANESTHESI OLOGY   0   0   05400   ANESTHESI OLOGY   0   0   05400   RADI OLOGY-DI AGNOSTI C   0   05401   RADI OLOGY - ULTRASOUND   0   05500   RADI OLOGY-THERAPEUTI C   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05501   INFUSI ON CENTER   0   05600   RADI OLOGY-THERAPEUTI C   0   05700   CT SCAN   0   05700   CT SCAN   0   05700   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   05900   CARDI AC CATHETERI ZATI ON   0   06001   BLOOD LABORATORY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   06400   INTRAVENOUS THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   RESPI RATORY THERAPY   0   06500   06500   RESPI RATORY THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06600   PHYSI CAL THERAPY   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06600   PHERAPI   0   06700   06700   0CCUPATI ONAL THERAPY   0   06700   06900   ELECTROCARDI OLOGY   0   06900   06900   ELECTROCARDI OLOGY   0   06900   06900   06900   0CCUPATI ONAL THERAPY   0   06700   0000   0000   0000   0000   0000   0000   00000   00000   00000   00000   00000   000000		6. 00	7. 00	8. 00	
50. 00         05000         OPERATI NG ROOM         0           50. 01         05001         ENDOSCOPY         0           51. 00         05100         RECOVERY ROOM         0           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0           53. 00         05300         ANESTHESI OLOGY         0           54. 01         05400         RADI OLOGY-DI AGNOSTI C         0           54. 01         05401         RADI OLOGY-THERASOUND         0           55. 00         05500         RADI OLOGY-THERAPEUTI C         0           55. 01         05501         I NFUSI ON CENTER         0           56. 00         05600         RADI OLOGY-THERAPEUTI C         0           57. 00         05700         CT SCAN         0           58. 00         05800         RADI OLOGY-THERAPEUTI C         0           57. 00         05700         CT SCAN         0           58. 00         05800         RADI OLOGY-THERAPEUTI C         0           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0           59. 00         05900         CARDI AC CATHETERI ZATI ON         0           60. 01         06000         LABORATORY		0.00	7.00	0.00	
51. 00	0		0 143, 066, 646	0.000000	50.00
52. 00	0		0 18, 868, 420	0.000000	50. 01
53. 00         05300         ANESTHESI OLOGY         0           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0           54. 01         05401         RADI OLOGY - ULTRASOUND         0           55. 01         05500         RADI OLOGY-THERAPEUTI C         0           55. 01         05501         INFUSION CENTER         0           66. 00         05600         RADI OI SOTOPE         0           57. 00         05700         CT SCAN         0           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0           59. 00         05900         CARDI AC CATHETERI ZATI ON         0           60. 01         06000         LABORATORY         0           60. 01         D6001         BLOOD LABORATORY         0           61. 00         PPP CLI NI CAL LAB SERVI CES-PRGM ONLY         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0           63. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0           64. 00         06400         INTRAVENOUS THERAPY         0           65. 00         06500         RESPI RATORY THERAPY         0           66. 00         06600	0		0 10, 077, 869	0.000000	51.00
54. 00       05400       RADI OLOGY - DI AGNOSTI C       0         54. 01       05401       RADI OLOGY - ULTRASOUND       0         55. 00       05500       RADI OLOGY - THERAPEUTI C       0         55. 01       05501       I NFUSI ON CENTER       0         56. 00       05600       RADI OI SOTOPE       0         57. 00       05700       CT SCAN       0         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0         59. 00       05900       CARDI AC CATHETERI ZATI ON       0         60. 00       06000       LABORATORY       0         60. 01       D6001       BLOOD LABORATORY       0         61. 00       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0         64. 00       06400       I NTRAVENOUS THERAPY       0         65. 00       06500       RESPI RATORY THERAPY       0         66. 00       06600       PHYSI CAL THERAPY       0         67. 00       06700       OCCUPATI ONAL THERAPY       0         68. 00       06800	0		0 4, 396, 544	0. 000000	1
54. 01	0		0	0. 000000	
55. 00         05500         RADI OLOGY-THERAPEUTI C         0           55. 01         05501         I NFUSI ON CENTER         0           56. 00         05600         RADI OI SOTOPE         0           57. 00         05700         CT SCAN         0           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0           59. 00         05900         CARDI AC CATHETERI ZATI ON         0           60. 00         06000         LABORATORY         0           60. 01         06001         BLOOD LABORATORY         0           61. 00         06100         PBP CLI NI CAL LAB SERVI CES-PRGM ONLY         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0           63. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0           64. 00         06400         I NTRAVENOUS THERAPY         0           65. 00         06500         RESPI RATORY THERAPY         0           66. 00         06600         PHYSI CAL THERAPY         0           67. 00         06700         OCCUPATI ONAL THERAPY         0           68. 00         06800         SPECH PATHOLOGY         0           69. 01	0		0 41, 086, 561	0. 000000	•
55. 01 05501 INFUSION CENTER 0 56. 00 05600 RADI OI SOTOPE 0 57. 00 05700 CT SCAN 0 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI ) 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 60. 00 06000 LABORATORY 0 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 INTRAVENOUS THERAPY 0 65. 00 06500 RESPI RATORY THERAPY 0 66. 00 06600 PHYSI CAL THERAPY 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0	0		0 18, 476, 481	0.000000	•
56. 00	0		0 20, 844, 494		
57. 00 05700 CT SCAN 0 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 59. 00 05900 CARDIAC CATHETERIZATION 0 60. 00 06000 LABORATORY 0 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 64. 00 06400 INTRAVENOUS THERAPY 0 65. 00 06500 RESPIRATORY THERAPY 0 66. 00 06600 PHYSICAL THERAPY 0 67. 00 06700 OCCUPATIONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 01 06901 CARDIAC REHAB 0 70. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	0		0 232, 368 0 15, 612, 820	0. 000000 0. 000000	
58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0           59. 00         05900         CARDI AC CATHETERI ZATI ON         0           60. 00         06000         LABORATORY         0           60. 01         06001         BLOOD LABORATORY         0           61. 00         06100         PBP CLI NI CAL LAB SERVI CES-PRGM ONLY           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0           63. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0           64. 00         06400         I NTRAVENOUS THERAPY         0           65. 00         06500         RESPI RATORY THERAPY         0           66. 00         06600         PHYSI CAL THERAPY         0           67. 00         06700         OCCUPATI ONAL THERAPY         0           68. 00         O6800         SPEECH PATHOLOGY         0           69. 01         06900         ELECTROCARDI OLOGY         0           69. 01         O6901         CARDI AC REHAB         0           70. 00         O7100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0	o		0 125, 859, 121	0.000000	
59. 00         05900         CARDI AC CATHETERI ZATI ON         0           60. 00         06000         LABORATORY         0           60. 01         06001         BLOOD LABORATORY         0           61. 00         06100         PBP CLI NI CAL LAB SERVI CES-PRGM ONLY           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0           63. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0           64. 00         06400         I NTRAVENOUS THERAPY         0           65. 00         06500         RESPI RATORY THERAPY         0           66. 00         06600         PHYSI CAL THERAPY         0           67. 00         06700         OCCUPATI ONAL THERAPY         0           68. 00         06800         SPEECH PATHOLOGY         0           69. 01         06900         ELECTROCARDI OLOGY         0           69. 01         06901         CARDI AC REHAB         0           70. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0	o		0 30, 600, 361	0. 000000	
60. 00 06000 LABORATORY 0 0 060. 01 06001 BLOOD LABORATORY 0 0 061. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 063. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 064. 00 06400 I NTRAVENOUS THERAPY 0 065. 00 06500 RESPI RATORY THERAPY 0 066. 00 06600 PHYSI CAL THERAPY 0 067. 00 06700 OCCUPATI ONAL THERAPY 0 06800 SPECH PATHOLOGY 0 06900 ELECTROCARDI OLOGY 0 06901 CARDI AC REHAB 0 070. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0	O		0 69, 051, 548	0. 000000	
61. 00	o		0 156, 224, 313	0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 0 65. 00 06500 RESPIRATORY THERAPY 0 66. 00 06600 PHYSI CAL THERAPY 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0	0		0 0	0. 000000	60. 01
63. 00 06300 BL00D STORING, PROCESSING & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 0 65. 00 06500 RESPIRATORY THERAPY 0 66. 00 06600 PHYSI CAL THERAPY 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 01 06900 ELECTROCARDI OLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0					61.00
64. 00	0		0 10, 016, 410	0.000000	
65. 00 06500 RESPI RATORY THERAPY 0 66. 00 06600 PHYSI CAL THERAPY 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07100 ELECTROENCEPHALOGRAPHY 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0	0		0	0. 000000	
66. 00 06600 PHYSI CAL THERAPY 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07100 ELECTROENCEPHALOGRAPHY 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0	0		0 0	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY 0 68. 00 06800 SPEECH PATHOLOGY 0 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 06901 CARDI AC REHAB 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0	0		0 45, 364, 538	0.000000	
68. 00	0		0 7, 884, 598 0 5, 990, 640	0. 000000 0. 000000	
69. 00   06900   ELECTROCARDI OLOGY   0   69. 01   06901   CARDI AC REHAB   0   07000   ELECTROENCEPHALOGRAPHY   0   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0	0		0 2, 614, 967	0.000000	
69. 01   06901   CARDI AC REHAB   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   071. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0	0		0 25, 691, 629	0.000000	
70. 00 O7000 ELECTROENCEPHALOGRAPHY 0 O71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	0		0 903, 058		ı
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	O		0 26, 186, 485	0. 000000	
	o		0 50, 588, 056	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0	0		0 27, 173, 221	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0	0		0 154, 261, 776	0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S 0			0 8, 671, 001	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS	0				
90. 00   09000   CLI NI C   0	-		0 25, 791, 599		
91. 00   09100   EMERGENCY   0	0	1, 069, 30			
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   200.00   Total (lines 50 through 199)   0	-		0 32, 354, 182 9 1, 151, 182, 245		92. 00 200. 00

Hoal th	Financial Systems	METHODI ST HOSPI	TAIS INC		In lie	u of Form CMS-:	2552_10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	N: 15-0002	Peri od:	Worksheet D	2332-10
	H COSTS	KVI CE OTHEK TASS	Trovider ex		From 01/01/2019	Part IV	
			'		To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
				XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	Inpati 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	8	Costs (col. 9	
		col. 7)	10.00	x col. 10)	12.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
	05000 OPERATING ROOM	0. 000000	104 447		0 10	0	50.00
50. 00 50. 01	05000 OPERATING ROOM	0.000000	196, 667 11, 706		0 10 0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	12, 755		0 1, 986	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	12, 755		0 1, 988	0	
53.00	05300 ANESTHESI OLOGY	0.000000	0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	116, 403		0 402	0	
54. 01	05401 RADI OLOGY - ULTRASOUND	0. 000000	24, 516		0 806	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	45, 374		0 0	0	55.00
55. 01	05501 I NFUSI ON CENTER	0. 000000	43, 374		0 0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	25, 712		0 0	0	56.00
57.00	05700 CT SCAN	0. 000000	355, 412		0 0	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	126, 935		0 0	Ö	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	68, 140		0 27	Ö	
60.00	06000 LABORATORY	0. 000000	861, 444		0 895	0	
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	37, 639		0 985	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	715, 398		0 1, 392	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 080, 470		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 875, 519		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	261, 668		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	40, 169		0 257	0	69.00
69. 01	06901 CARDI AC REHAB	0. 000000	0		0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	16, 258		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	147, 813		0 1, 868	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	65, 071		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 672, 790		0 3	0	
	07400 RENAL DIALYSIS	0. 000000	335, 576		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	724		0 0	0	
	09100 EMERGENCY	0. 014590	12, 134	17		2	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
200.00	Total (lines 50 through 199)		10, 106, 293	17	7 8, 788	2	200. 00

Health Financial Systems	METHODI ST HOS				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der C		Peri od: From 01/01/2019	Worksheet D Part V	
		Component	CCN: 15-T002	To 12/31/2019	Date/Time Pre	pared:
		· ·			6/25/2020 8:0	3 am
		Title	: XVIII	Subprovi der -	PPS	
			Ch =	IRF	C+-	
Cost Center Description	Cost to	PPS	Charges Cost	Cost	Costs PPS Services	
cost center bescriptron	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not	(See Thst.)	
	Worksheet C.	inst.)	Subject To	Subject To		
	Part I, col.	11131.	Ded. & Coins	,		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	0. 100626	10		0 0	1	50.00
50. 01   05001   ENDOSCOPY	0. 196867	0		0	0	50.01
51. 00   05100   RECOVERY ROOM	0. 252235	1, 986		0	501	51.00
52.00   05200   DELI VERY ROOM & LABOR ROOM	1. 213243	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 208272	402		0 0	84	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 154560	806		0	125	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 161765	0		0	0	55.00
55. 01   05501   I NFUSI ON CENTER	0. 150425	0		0	0	55. 01
56. 00   05600   RADI 01 SOTOPE	0. 199985	0		0	0	56.00
57. 00  05700   CT   SCAN	0. 037618	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 062594	0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 084238	27		0	2	59.00
60. 00   06000   LABORATORY	0. 101285	895		0	91	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62.00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 209857	985		0	207	62.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000	0	l .	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 117574	1, 392		0	164	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 358241	0	•	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 396530	0	•	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 317808	0	•	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 056511	257		0	15	69.00
69. 01   06901   CARDI AC REHAB	0. 716231	0	l .	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 071394	0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341883	1, 868		0	639	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 535503	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 170061	3		0	1	73.00
74. 00 O7400 RENAL DIALYSIS	0. 310666	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	0.390056	0	1	0 0	2	00.00
90 00 09000 CLINIC	1 0 390056	1 ()	I	0	0	90.00

0. 390056

0. 252212

0. 530055

40

0 92.00 1, 870 200. 00

1, 870 202. 00

0

157

8, 788

8, 788

90.00

91.00

201.00

90.00

91.00

202.00

09000 CLI NI C

09100 EMERGENCY

Only Charges

92.00 09200 DSSERVATION BEDS (NON-DISTINCT PART)
200.00 Subtotal (see instructions)
201.00 Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	METHODIST HOS				of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C	CN: 15-0002	Peri od: From 01/01/2019	Worksheet D Part V	
		Component	CCN: 15-T002	To 12/31/2019	Date/Time Pro 6/25/2020 8:0	epared: 03 am
		Title	: XVIII	Subprovi der - I RF	PPS	
	Co	sts			<b>'</b>	
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
ANOLILIA DIVI OFFICIA DE COOT, OFFITEDO	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS		) O				
50. 00   05000   OPERATING ROOM	C		1			50.00
50. 01   05001   ENDOSCOPY 51. 00   05100   RECOVERY ROOM		1	1			
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM						51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		0	•			53. 00 54. 00
54. 01   05400   RADI OLOGY - DI AGNOSTI C			1			54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C						55.00
55. 01   05501   NFUSI ON CENTER						55. 01
56. 00   05600   RADI OI SOTOPE			1			56.00
57. 00 05700 CT SCAN		ol ö	1			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)						58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		ol o				59.00
60. 00   06000   LABORATORY		ol o				60.00
60. 01   06001   BLOOD LABORATORY			1			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		ol o				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	o				63.00
64. 00 06400 I NTRAVENOUS THERAPY	C	0				64.00
65. 00 06500 RESPIRATORY THERAPY	C	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	) 0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	C	) 0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	•			73.00
74. 00 07400 RENAL DIALYSIS	C	0				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C		)l o				90.00

0

0

0

0

90.00

91.00

92.00

200.00

201.00

202.00

90. 00 09000 CLI NI C

91.00

200.00 201.00

202.00

09100 EMERGENCY

Only Charges

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

					6.5. 0110.6	
		ETHODIST HOSPITALS, I		In Lieu	of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provi	der CCN: 15-0002	Peri od:	Worksheet D-1	
				From 01/01/2019		
				To 12/31/2019		
					6/25/2020 8: 0	3 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and	d swing-bed days, excl	uding newborn)		84, 762	1.00
2.00	Inpatient days (including private room days, ex	kcluding swing-bed and	d newborn days)		84, 762	2.00
3.00	Private room days (excluding swing-bed and obse	ervation bed days). I	f you have only p	rivate room days,	0	3.00
	do not complete this line.			Ť		
4.00   Semi-private room days (excluding swing-bed and observation bed days) 64,992					4.00	
5. 00	Total swing-bed SNF type inpatient days (include	ding private room day	s) through Decemb	er 31 of the cost	0	5.00
	reporting period	· · · · · · · · · · · · · · · · · · ·	,			
6. 00	Total swing-bed SNF type inpatient days (include	ding private room day	s) after December	31 of the cost	0	6.00
			-,		-	

	Cost Center Description		
	NACT L ALL DOUBLES COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	84, 762	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	84, 762	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	01,702	3.00
0.00	do not complete this line.	Ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	64, 992	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	22 140	0 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	22, 149	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	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 titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT  Medicago rate for awing had SNE comitions applicable to comitions through December 31 of the cost	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	73, 526, 910	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6   x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	١	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	73, 526, 910	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00		0	28. 00
	Private room charges (excluding swing-bed charges)	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	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.00
37.00	27 minus line 36)	, 3, 320, 710	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	867. 45	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	19, 213, 150	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	19, 213, 150	41.00

	reporting perrod		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	o o	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	22, 149	9. 00
	newborn days) (see instructions)	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through 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	0	11.00
	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 titles V or XIX only (including private 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 XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT	-	
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20.00	reporting period	0.00	20. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	73, 526, 910	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
27 00	x line 20)	0	27 00
26. 00	Total swing-bed cost (see instructions)	72 524 010	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	73, 526, 910	27.00
28. 00		0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
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)		32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	73, 526, 910	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0/7 45	20.00
38.00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	867. 45 19, 213, 150	
39. 00 40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	19, 213, 150	
	Total Program general inpatient routine service cost (line 39 + line 40)	19, 213, 150	
41.00	Total Trogram general impatrent routine service cost (The 37 + The 40)	17, 213, 130	71.00

Provider CDL 15.000   Part of UNITY   Provider CDL 15.000   Part of UNITY   Provider CDL 15.000   Part of UNITY   Propries and UNITY   Provider CDL 15.000   Provider CDL 15.0000   Provider CDL 15.000   Provider CDL 15.		Financial Systems	METHODIST HOS				u of Form CMS-2	
Cost Center Description    Total   Total   Total   Total   Description   Total   Total   Description   Total   Description   Total   Description   Descripti	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C	F	rom 01/01/2019	Worksheet D-1	
Cost Center Description				T: +1 o			6/25/2020 8: 0	3 am
		Cost Center Description	I npati ent	Total I npati ent	Average Per Diem (col. 1	·	Program Cost (col. 3 x	
Interest vie Care Type Inpatient Hospital Units:  10 INTEREST CARE UNIT:  11	42 00	NURSERY (title V & XIX only)						42.00
		Intensive Care Type Inpatient Hospital Units						
1.00	43. 01 44. 00 45. 00 46. 00	NEONATAL ICU CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			1			43. 01 44. 00 45. 00 46. 00
49.00		·					1. 00	
50.00   Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 2,078,435 50.00		Total Program inpatient costs (sum of lines			ons)			1
1.439, 335 51.00	50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	2, 078, 435	50.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	1, 439, 335	51.00
54.00   Program discharges   0.0   55.00   55.00   Target amount per discharge   0.0   55.00   56.00   Target amount per discharge   0.0   55.00   56.00   Target amount (line 54 x line 55)   0.0   56.00   56.00   56.00   57.00   0.0   57.00   0.0   57.00   0.0   57.00   0.0   58.00   0.0		Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital r	el ated, non-ph	ysician anesth	etist, and		
55.00   Target amount per discharge   0.00   55.00   0.00   55.00   0.	54.00						0	54.00
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00	55.00	Target amount per discharge						•
Sy, 00   Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   60.00	57.00	Difference between adjusted inpatient operat	ing cost and t	arget amount (	line 56 minus	line 53)	0	57.00
61.00 which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Rich expected (see instructions)  63.00 PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) and (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60 Adjusted general inpatient routine service cost (line 70 + line 2)  70.00 Skilled nursing facility/other nursing facility/Tot/FIID routine service cost (line 37)  71.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  72.00 Program routine service cost (line 75 + line 2)  73.00 Total Program general inpatient routine service costs (from provider records)  74.00 Program capital -related costs (line 75 + line 2)  75.00 Program capital -related costs (line 74 minus line 77)  78.00 Program inpatient routine service cost (see instructions)  80.00		00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF Inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 58) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 16 x line 25) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Program capital-related costs (line 75 + line 2) 79.00 Aggregate charges to beneficiarles for excess		.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						1
PROGRAM INPATIENT ROUTINE SWING BED COST  4. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  6. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  6. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions)  6. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions)  6. 00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  6. 00 Total title V or XIX swing-bed NF inpatient costs after December 31 of the cost reporting period (line 13 x line 20)  6. 00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  6. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  6. 00 Apart III - SXLILED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/ID ONLY  7. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  7. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  7. 00 Porgram routine service cost (line 9 x line 71)  7. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  7. 00 Capital-related costs (line 9 x line 76)  7. 00 Per diem capital-related costs (line 9 x line 76)  7. 00 Program capital-related costs (line 9 x line 76)  7. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  8. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  8. 00 Inpatient routine service cost (line 9 x line 81)  8. 00 O Total Program routine service costs (see instructions)  8. 00 O Total Program inpatient ancillary services (see instructions)  8. 00 O Total Program inpatient oncompensation (s		.00 Relief payment (see instructions)						1
65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00   Total title V or XIX swing-bed NF inpatient routine service cost (line 37)  70.00   Skilled nursing facility/other nursing facility/IcF/IID routine service cost (line 37)  71.00   Program routine service cost (line 9 x line 71)  72.00   Program routine service cost (line 9 x line 71)  73.00   Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00   Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00   Per diem capital-related costs (line 75 + line 2)  77.00   Program capital-related costs (line 75 + line 2)  77.00   Total Program routine service costs (from provider records)  78.00   Inpatient routine service cost per diem limitation  80.00   Inpatient routine service cost per diem limitation  81.00   Nagregate charges to beneficiaries for excess costs (from provider records)  82.00   Inpatient routine service cost per diem limitation  83.00   Reasonable inpatient routine service (see instructions)  84.00   Program inpatient routine service (see instructions)  85.00   Vilia in the cost per line 20 per line 30		PROGRAM INPATIENT ROUTINE SWING BED COST						
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost end (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Total Program routine service cost (line 74 ninus line 77) 78.00 Program routine service cost (line 74 ninus line 77) 78.00 Inpatient routine service cost (see instructions) 80.00 Inpatient routine service cost (see instructions) 81.00 Unpatient routine service cost (see instructions) 82.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient noutine service (see instructions) 87.00 Total Program inpatient poerating costs (sum of lines 83 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 + line 2)	65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	period (See	0	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 19.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 10 Inpatient routine service cost limitation (line 9 x line 81) 81.00 11 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of I line 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 867.45 88.00	66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/Other nursing facility/IGF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	h December 31 (	of the cost re	porting period	0	67. 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72. 00 Program routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (line 72 + line 73)  75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76. 00 Program capital-related costs (line 75 ÷ line 2)  77. 00 Program capital-related costs (line 9 x line 76)  78. 00 Inpatient routine service cost (line 74 minus line 77)  79. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  80. 00 Total Program routine service cost per diem limitation  81. 00  82. 00 Inpatient routine service cost per diem limitation  81. 00  82. 00 Reasonable inpatient routine service costs (see instructions)  84. 00 Program inpatient ancillary services (see instructions)  85. 00 Utilization review - physician compensation (see instructions)  87. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  86. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  86. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after I	December 31 of	the cost repo	rting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 74 minus line 77) 80.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine service diem (line 27 + line 2) 87.00 Adjusted general inpatient routine service cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 886.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 887.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 887.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	69. 00						0	69. 00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 867.45 88.00		Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service (	cost (line 37)			1
Total Program general inpatient routine service costs (line 72 + line 73)  75.00  75.00  76.00  76.00  76.00  77.00  77.00  78.00  79.00  79.00  70.0	72.00	Program routine service cost (line 9 x line	71)		ŕ			72.00
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								1
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		26, line 45)		e costs (from \	Worksheet B, Pa	art II, column		
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	77. 00	Program capital-related costs (line 9 x line	76)					77. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine								1
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (sum of line 81) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instruc		00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	82.00	2.00   Inpatient routine service cost limitation (line 9 x line 81)						82.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								1
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  867.45 88.00	85.00	Utilization review - physician compensation	(see instructi					85. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 867.45 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				=	
	88. 00	Adjusted general inpatient routine cost per	diem (line 27				867. 45	88. 00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		pared: 3 am
		Title	XVIII	Hospi tal	PPS	
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	6, 836, 028	73, 526, 910	0. 09297	3 17, 149, 487	1, 594, 439	90.00
91.00 Nursing School cost	0	73, 526, 910	0.00000	0 17, 149, 487	0	91.00
92.00 Allied health cost	0	73, 526, 910	0.00000	0 17, 149, 487	0	92.00
93.00 All other Medical Education	0	73, 526, 910	0.00000	0 17, 149, 487	l 0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1
	Component CCN: 15-S002	From 01/01/2019 To 12/31/2019	
	Title XVIII	Subprovi der -	PPS
		I PF	

PART I. A. IL. REPOVIDER COMPONENTS   1.00			I PF		
NAMEDIE MANS   NAME		Cost Center Description		1 00	
IRACHERT DAYS		DADT I _ ALL DDOVLDED COMPONENTS		1.00	
Impatient days (including private room days and swing-bed days, excluding neeborn)   3,016   1,00   2,00   1,00   1,00   1,00   2,00   1,00   1,00   2,00   1,00   2,00   1,00   2,00   1,00   2,00   1,00   2,00   1,00   2,00   1,00   2,00					
1.00   Inignation todays (including private room days)   1.00   2.00   3.00   6.00   3.00   3.00   6.00   3.00	1. 00			3, 016	1.00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.01 Total swing-bed SW type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendary year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendary year, enter 0 on this line).  8.01 Total swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendary year, enter 0 on this line).  8.02 Interest of the swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendary year, enter 0 on this line).  8.03 Interest of the swing-bed WF type inpatient days. (including private room days) after December 31 of the cost reporting period (see instructions).  8.04 Interest of the swing-bed WF type inpatient days applicable to the Program (excluding swing-bed and newborn days).  9.05 Swing-bed SWF type inpatient days applicable to title WIII in July (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  9.05 Swing-bed SWF type inpatient days applicable to title WIII in July (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  9.06 Swing-bed SWF type inpatient days applicable to swing-bed swing-bed days).  9.07 Interest of the cost reporting period (if calendary year, enter 0 on this line).  9.08 Swing-bed SWF type inpatient days applicable to swing-bed swing-bed days).  9.09 Interest of the cost reporting period (if calendary year, enter 0 on this line).  9.00 Interest of the cost reporting period (if calendary year, enter 0 on this line).  9.00 Interest of the cost reporting period (if calendary year, enter 0 on this					
Semi-private room days (excluding swing-bed and observation bed days)   Semi-private room days (including private room days) through December 31 of the cost   0   5.00			ate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,363 9.00 including perivate room days) including private prome days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days applicable to title SVI or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total nursery days (title V or XIX only)  Total nursery days (title V or XIX only)  Total nursery days (title V or XIX only)  Medical rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (in period reporting period (in period period on the period period (in per					
reporting period (if calendar year, enter 0 on this line)  7.00  7	4.00			3, 016	
10   10   10   10   10   10   10   10	5.00		31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of the swing-bed NF year inpatient days (including private room days) after December 31 of the cost of the swing-bed NF year inpatient days (and only applicable to the Program (excluding swing-bed and newborn days) (see landing year, enter 0 on this line) on the swing-bed NF year inpatient days applicable to the Program (excluding swing-bed and newborn days) (see landing year)				0	, 00
Total swing-bed NF type inpatient days (including private room days) after 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)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.3.63 7.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.3.63 7.00   Total inpatient days applicable to the Ital XIVI (in only (including private room days)   Total inpatient days applicable to the Ital XIVI (in only (including private room days)   Total inpatient days applicable to the Ital XIVI (in only (including private room days)   Total Inpatient days applicable to the Ital XIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days applicable to Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (including private room days)   Total Inpatient days (in Ital Ex VIVI (in only (in Ital Ex VIVI (in only (including private room days)   Total Inpatient routine service applicable to services after Decem	6.00		or the cost	U	6.00
reporting period  8	7 00		I of the cost	0	7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if C aclendar year, enter 0 on this line)	7.00		i or the cost	J	7.00
1. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 0.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0.00 December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 SMF type days (title V or XIX only) 1.00 SMF type days (title V or XIX only) 1.00 SMF type services applicable to services through December 31 of the cost 1.00 SMF type services applicable to services after December 31 of the cost 1.00 SMF type services applicable to services after December 31 of the cost 1.00 SMF type services through December 31 of the cost 1.00 SMF type services through December 31 of the cost 1.00 SMF type services through December 31 of the cost 1.00 SMF type services through December 31 of the cost 1.00 SMF type services through December 31 of the cost 1.00 SMF type services through December 31 of the cost reporting period (line 1.00 SMF type services through December 31 of the cost reporting period (line 1.00 SMF type services through December 31 of the cost reporting period (line 1.00 SMF type services through December 31 of the cost reporting period (line 1.00 SMF type services through December 31 of the cost reporting period (line 1.00 SMF type services through Decem	8.00		of the cost	0	8. 00
newborn days) (see instructions)  10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SMF 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 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 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through 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 (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 (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed SNF services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type serv					
10.00 Swing-bed SMF Type inpatient days applicable to title XVIII only (including private room days) after bed through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SMF Type inpatient days applicable to title XVIII only (including private room days) after bed	9. 00		ving-bed and	1, 363	9. 00
through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medical ly necessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only) 0 15.00 Noursery days (title V or XIX only) 0	10.00			0	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to 1tles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to 1tles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to 1tles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Namsery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of reporting period of swing-bed NF services applicable to services after December 31 of the cost reporting period of swing-bed NF services applicable to services after December 31 of the cost reporting period of swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period of swing-bed NF services applicable to services after December 31 of the cost reporting period of swing-bed NF services applicable to services after December 31 of the cost reporting period of swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x X line 18)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x X line 18)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X line 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X line 18)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X line 18)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost (see instructions)  28.	10.00		n days)	U	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00	11 00		davs) after	0	11 00
12.00   Swing-bed NF type inpatient days applicable to titles \( \tilde{\tilde{V}} \) or XIX only \( \tilde{V} \) including private room days \( \tilde{V} \) or \(	11.00		auys) arter	o .	11.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   0   13.00	12.00		room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15			_		
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   16.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00	13. 00		room days)	0	13. 00
15.00	14 00		\	0	14 00
16.00 Nursery days (title V or XIX only)			/S)		
SWING BED ADJUSTMENT					
17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00   18.00   18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18.00   19.0	10.00			J	10.00
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  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 through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 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)  27.00 Total swing-bed cost (see instructions)  28.00 Total swing-bed cost (see instructions)  29.00 Total swing-bed cost (see instructions)  20.00 Semi-private room charges (excluding swing-bed cost (line 21 minus line 26)  20.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  20.00 Average private room per diem charge (line 29 + line 3)  20.00 Average private room per diem charge (line 29 + line 3)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 35)  20.00 Average per diem private room cost differential (line 3 x line 35)  20.00 Average per diem private room cost differential (line 3 x line 35)  20.00 Average per diem private room cost differential (line 3 x line 35)  20.00 Average per diem	17. 00		the cost	0.00	17. 00
reporting period  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period reporting period  10.00  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost cost (see instructions)  Total general inpatient routine service cost (see instructions)  2, 310, 655  21.00  Total general inpatient routine service cost (see instructions)  33.00  Nung-bed cost applicable to SNF type services after December 31 of the cost reporting period (line only in the cost in the cost applicable to services after December 31 of the cost reporting period (line only in the cost					
19.00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   2	18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the	e cost	0. 00	18.00
reporting period Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00 reporting period in patient routine service cost (see instructions) 2. 00 Total general inpatient routine service cost (see instructions) 2. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 2. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18) 2. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 0 24.00 7 x line 19) 2. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 20) 2. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 2. 00 Total swing-bed cost (see instructions) 2. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 2. 00 Total swing-bed cost (see instructions) 2. 01 Total swing-bed cost (see instructions) 2. 02 Swing-bed cost (see instructions) 2. 03 Swing-bed cost (see instructions) 2. 04 Swing-bed cost (see instructions) 3. 05 Swing-bed cost (see instructions) 3. 00 Swing-bed cost (see instructions) 3. 00 Average perivate room per diem charge (line 29 + line 30) 3. 00 Average perivate room per diem charge (line 20 + line 30) 3. 00 Average perivate room cost differe	40.00				40.00
Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   20.00   20.0	19.00		ne cost	0.00	19.00
reporting period  Total general inpatient routine service cost (see instructions)  22. 00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  33. 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 through December 31 of the cost reporting period (line 7 x line 19)  25. 00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  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 ROMD DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  O 29. 00  Private room charges (excluding swing-bed charges)  O 29. 00  Semi-private room charges (excluding swing-bed charges)  O 29. 00  Semi-private room per diem charge (line 29 + line 3)  Average per diem private room charge (line 29 + line 3)  Average per diem private room charge (line 30 + line 4)  Average per diem private room charge (line 30 + line 3)  O Average per diem private room charge (line 30 + line 3)  O Private room cost differential (line 34 x line 31)  O Average per diem private room charge (line 30 + line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per diem private room cost differential (line 34 x line 31)  O Average per	20 00		cost	0.00	20 00
21.00   Total general inpatient routine service cost (see instructions)   2, 310,655   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)   22.00   23.00   24.00   24.00   25.00   24.00   24.00   25.00   25.00   25.00   26.00   25.00   26	20.00		0031	0.00	20.00
5 x line 17)  23.00 x line 18)  24.00 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 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)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 Average per diem private room per diem charge (line 30 + line 4)  32.00 Average per diem private room cost differential (line 3 x line 31)  32.00 Average per diem private room cost differential (line 3 x line 31)  33.00 Private room cost differential adjustment (line 3 x line 35)  34.00 Average per diem private room cost differential (line 3 x line 35)  35.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Program general inpatient routine service cost per diem (see instructions)  37.00 Comparition (line 2, 310, 655)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Wedically necessary private room cost differential (the 10 x line 35)  40.00 Wedically necessary private room cost differential (line 3 x line 31)  40.00 Wedically necessary private room cost differential (line 9 x line 38)  40.00 Wedically necessary private room cost differential (line 10 x line 10 x	21.00			2, 310, 655	21.00
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 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Perivate room charges (excluding swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  29.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average per diem private room per diem charge (line 29 + line 3)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 35 minus line 36)  30.00 Private room cost differential djustment (line 35 minus line 36)  30.00 Average per diem private room cost differential (line 27 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average per diem private room cost differential (line 37 minus line 36)  30.00 Average pe	22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting	period (line	0	22.00
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 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 310, 655 27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000  32.00 Average private room per diem charge (line 29 + line 3) 0.00  33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00  35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00  36.00 Formal inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655 0)  Average per diem private room cost differential (line 3 x line 31) 0.00  36.00 Private room cost differential service cost net of swing-bed cost and private room cost differential (line 2, 310, 655 0)  Average per diem private room cost differential (line 3 x line 35) 0.00  37.00 General inpatient routine service cost per diem (see instructions) 766.13  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.13  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.13  38.00 Program general inpatient routine service cost per diem (see instructions) 766.13  39.00 Program general inpatient routine service cost per diem (see instructions) 766.13  39.00 Program general inpatient routine service cost per diem (see i					
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 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Semi-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)  31.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 34 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 Private room cost differential eservice cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		period (line of	0	23. 00
7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8  0 25.00  x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  10 29.00  29.00  29.00  Semi-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 29 ÷ line 3)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 3 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  30 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 38)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service	24.00		poriod (lipo	0	24 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 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) 28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655) 37.00 Agdisted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 (40.00	24.00		perrou (Trile	U	24.00
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)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average pri vate room per diem charge (line 29 + line 3)  30.00 Average semi-pri vate room per diem charge (line 30 + line 4)  31.00 Average per diem pri vate room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem pri vate room cost differential (line 34 x line 31)  33.00 Average per diem pri vate room cost differential (line 3 x line 35)  34.00 Average per diem pri vate room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655 and 0)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26.00  26.00  27.00 Private room cost differential (line 2, 310, 655 and 0)  28.00  29.00  29.00  20.00  20.00  20.00  20.00  20.00  30.00	25. 00		eriod (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average per diem private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 35)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  766. 13 7. 04, 235 7. 04. 05 7. 04. 05 7. 04. 05 7. 04. 05 7. 05 7. 04. 05 7. 05 7. 06 7. 06 7. 07 7. 07 7. 08 7. 09 7. 09 7. 09 7. 09 7. 00 7.			,		
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average pri vate room per diem charge (line 29 ± line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ± line 4)  33.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem pri vate room cost differential (line 34 x line 31)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 28.00  28.00 29.00  28.00 29.00  29.00 29.00  20.00  20.00  20.00  30.00  30.00  31.00  32.00  32.00  32.00  32.00  33.00  34.00  35.00  36.00  37.00  36.00  37.00  36.00  37.00  38.00  38.00  39.00  39.00  40.00  40.00					
28.00 General inpatient routine service 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)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Average per diem private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 FART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  29.00  29.00  20.00  20.00  30.00  0.0000000  31.00  0.0000000  31.00  0.0000000  32.00  32.00  32.00  32.00  32.00  32.00  33.00  34.00  35.00  Average per diem private room cost differential (line 3 x line 31)  0.00 35.00  36.00  37.00  36.00  37.00  38.00  38.00  39.00  40.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	27. 00			2, 310, 655	27. 00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  30.00	00.00			0	00.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655) 37.00 FART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			ges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)  33.00 Average per diem private room cost differential (line 32 minus line 33)  34.00 Private room cost differential (line 3 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Average private room cost applicable to the Program (line 14 x line 35)  31.00 Average per diem charge (line 29 ÷ line 28)  32.00 Average per diem private room cost differential (line 2, 310, 655)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  3					
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.00 0.00 3					
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 35.00  37.00 36.00  37.		, , , , , , , , , , , , , , , , , , , ,			
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00 36.00  2, 310, 655 37.00  37.00 37.00  37.00 37.00 37.00					
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  766.13 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	34.00		ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 310, 655 and private room cost differential (line 2, 310, 655 and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost and private room cost and private room cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost and private room cost and private room cost differential (line 2, 310, 655 and patient routine service cost and private room cost		, , ,		0. 00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, , , , , , , , , , , , , , , , , , , ,			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.13 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,044,235 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		erential (line	2, 310, 655	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 39.00 Program general inpatient routine service cost per diem (see instructions) 766.13					
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  766. 13 38.00  769. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00  760. 13 38.00					
39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,044,235 39.00  40.00	38 00		T	766 13	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					
		, , , , , , , , , , , , , , , , , , , ,		0	40.00
	41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1, 044, 235	41.00

		Component	CCN: 15-S002	To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Title	e XVIII	Subprovi der -	PPS	is alli
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Pe Diem (col. ÷ col. 2)	r Program Days	Program Cost (col. 3 x col. 4)	
NIIDSEDV (+i +l o V & VI V opl v)	1. 00	2.00	3.00	4. 00	5. 00	42.00
Intensive Care Type Inpatient Hospital Units			л О.	00	] 0	42.00
INTENSIVE CARE UNIT	0					
CORONARY CARE UNIT						44.00
						45.00
						46. 00 47. 00
Cost Center Description			1			47.00
					1.00	10.00
			ons)		144, 901 1, 189, 136	
PASS THROUGH COST ADJUSTMENTS			- WI - I - D	G David L	47.547	1
	atient routine	services (fro	m WKST. D, S	um of Parts I and	46, 546	50.00
Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	4, 908	51.00
	50 and 51)				51 454	52 00
Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	ıysi ci an anes	thetist, and	1, 137, 682	
	52)					-
					0	54.00
					1	55.00
Target amount (line 54 x line 55)				==>	0	
, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	rget amount (	line 56 minu	s line 53)		
	porting period	endi ng 1996,	updated and	compounded by the		59.00
market basket						
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						1
	0	62.00				
	ent (see instru	ctions)				63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						4
	ts through Dece	mber 31 of th	ie cost repor	ting period (See	0	64.00
Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporti	ng period (See	0	65.00
Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	III only). For	0	66.00
	e costs through	December 31	of the cost	reporting period	0	67.00
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost re	porting period	0	68.00
(line 13 x line 20)				. 31	0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NU	URSING FACILITY	, AND ICF/IID	ONLY			1
	,			7)		70.00
		ine /U ÷ IIN6	: 2)			71.00
, ·		(line 14 x l	ine 35)			73.00
				De al III		74.00
	routine service	costs (from	worksheet B,	Part II, column		75.00
	ne 2)					76.00
						77.00
		rovider recor	·ds)			78. 00 79. 00
				inus line 79)		80.00
Inpatient routine service cost per diem limi	tati on		,	,		81.00
						82.00
		5)				83.00
		ns)				85.00
Total Program inpatient operating costs (sum	of lines 83 th					86.00
						87.00
		line 2)			1	88.00
	INTENSIVE CARE UNIT NEONATAL ICU CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT JOTHER SPECIAL CARE (SPECIFY) Cost Center Description  Program inpatient ancillary service cost (WK Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp III) Pass through costs applicable to Program inp III) Pass through costs applicable to Program inp and IV) Total Program excludable cost (sum of lines Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operat Bonus payment (see instructions) Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routin CAH (see instructions) Title V or XIX swing-bed NF inpatient routin CAH (see instructions) Total Program general inpatient routine service Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine service Capital -related costs (line 75 ÷ li Program capital -related costs (line 75 ÷ li Program capital -related costs (line 9 x line Inpatient routine service cost (line 75 ÷ li Program capital -related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program inpatient routine service costs (sum PART IV - COMPUATION OF OBSERVATION	NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT  NEONATAL ICU  CORONARY CARE UNIT  SURGICAL INTENSIVE CARE UNIT  OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  Program inpatient ancillary service cost (Wkst. D-3, col. 3  Total Program inpatient costs (sum of lines 41 through 48) (PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine  III)  Pass through costs applicable to Program inpatient ancillar and IV)  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital re medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and ta Bonus payment (see instructions)  Lesser of lines 53/54 or 55 from the cost reporting period market basket  Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 which operating costs (line 53) are less than expected cost amount (line 56), otherwise enter zero (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Medicare swing-bed SNF inpatient routine costs through Dece Instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs after Decemb instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs per diem (I Program routine service cost (line 9 x line 76)  Program and program general inpatient routine ervice cost per diem (I Program general inpatient routine service cost (line 75 + line 2)  Program capital-related costs (line 75 + line 2)  Program and program general inpatient routine service costs (from program general inpatient routine service cost (line 77)  Aggregate charges to benefi	NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT  ROWATAL ICU  COROMARY CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  Frogram inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  Total Program inpatient costs (sum of lines 41 through 48) (see instructions)  Pass through costs applicable to Program inpatient routine services (from and IV)  Total Program inpatient costs (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-phimedical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (Bonus payment (see instructions))  Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, market basket  Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, market basket  Lesser of lines \$3/54 is less than the lower of lines 55, 59 or 60 enter the less which operating costs (line 53) are less than expected costs (lines 54 x amount (line 56), otherwise enter zero (see instructions)  Rel lef payment (see Instructions)  Total Modera sing-bed SNF inpatient routine costs through December 31 of the instructions) (title XVIII only)  Medicare sing-bed SNF inpatient routine costs after December 31 of the Instructions) (title XVIII only)  Medicare sing-bed SNF inpatient routine costs after December 31 of the Instructions) (title XVIII only)  Medicare sing-bed SNF inpatient routine costs (line 64 plus line CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs (line 70 + line PART III - SKILED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID  SKILIED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID  SKILIED NURSING FACILITY, OTHER NURSING	NURSERY (title V & XIX only)  NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT  NEONATAL ICU  COROMARY CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  Total Program inpatient costs (sum of lines 41 through 48) (see instructions)  PASS THROUGH COST ADJUSTMENTS  PASS THROUGH COST ADJUSTMENTS  PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine services (from Wkst. D, and IV)  Total Program inpatient ocats (sum of lines 50 and 51)  Total Program inpatient ocats (sum of lines 50 and 51)  Total Program inpatient ocats (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-physician anesmodial education costs (line 49 minus line 52)  Program discharges  Target amount per discharge  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus anaket basket)  Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket    Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket    Lesser of lines 53/54 is less than the lower of lines 55, 5 or 60 enter the lesser of 50% owhich operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Relief payment (see instructions)  Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost report instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only)  Program dispared to the patient co	NURSERY (title V & XIX only)    1.00	NUBSERY (LITTLE V. & XIX only)

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2019	Worksheet D-1	
C		Component (	Component CCN: 15-S002		Date/Time Pre 6/25/2020 8:0	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
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	103, 008	2, 310, 655	0. 04458	30 0	0	90.00
91.00 Nursing School cost	0	2, 310, 655	0.00000	00	0	91.00
92.00 Allied health cost	0	2, 310, 655	0.00000	00	0	92.00
93.00 All other Medical Education	0	2, 310, 655	0.00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1
	Component CCN: 15-T002	From 01/01/2019 To 12/31/2019	
	Title XVIII	Subprovi der -	PPS
		IRF	

			I RF		
	Cost Center Description		-	1. 00	
PAR <sup>2</sup>	T I - ALL PROVIDER COMPONENTS			1.00	
	ATLENT DAYS				
	patient days (including private room days and swing-bed day			7, 786	
	patient days (including private room days, excluding swing- vate room days (excluding swing-bed and observation bed da		vate room days	7, 786 0	3.00
	not complete this line.	ys). The you have only pri	vate room days,	O	3.00
4.00 Sem	ni-private room days (excluding swing-bed and observation b	ed days)		7, 786	4.0
	al swing-bed SNF type inpatient days (including private ro	om days) through Decembe	31 of the cost	0	5.00
	orting period al swing-bed SNF type inpatient days (including private ro	om days) after December (	21 of the cost	0	6.00
	orting period (if calendar year, enter 0 on this line)	on days) arter becember .	of the cost	U	0.00
	ral swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.0
	porting period				
	al swing-bed NF type inpatient days (including private roo	m days) after December 3°	1 of the cost	0	8.0
	porting period (if calendar year, enter 0 on this line) cal inpatient days including private room days applicable t	n the Program (evoluding	swing-bod and	4, 740	9.0
	born days) (see instructions)	o the frogram (excruding	Swifig-bed and	4, 740	7.0
	ng-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	oom days)	0	10.0
	rough December 31 of the cost reporting period (see instruc				
	ng-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	cember 31 of the cost reporting period (if calendar year, e ng-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
thr	rough December 31 of the cost reporting period	wom'y (meradring private	c room days)	O	12.00
	ng-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.0
	er December 31 of the cost reporting period (if calendar y				
	lically necessary private room days applicable to the Progr	am (excluding swing-bed o	days)	0	14.0
	al nursery days (title V or XIX only) sery days (title V or XIX only)			0	15. 0 16. 0
	NG BED ADJUSTMENT			U	10.0
	licare rate for swing-bed SNF services applicable to servic	es through December 31 of	f the cost	0.00	17.0
	porting period	-			
	licare rate for swing-bed SNF services applicable to servic	es after December 31 of <sup>-</sup>	the cost	0. 00	18.00
	orting period Hicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.0
	porting period	3 through becomber 31 of	the cost	0.00	17.0
	licaid rate for swing-bed NF services applicable to service	s after December 31 of th	ne cost	0. 00	20.00
	porting period				
	al general inpatient routine service cost (see instruction ng-bed cost applicable to SNF type services through Decemb		ng poriod (line	6, 846, 801 0	21. 00 22. 00
	Tig-bed cost applicable to sire type services through becemb ( line 17)	er 31 of the cost reporti	ng perrou (Trie	U	22.00
1	ng-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23.00
4	ine 18)				
	ng-bed cost applicable to NF type services through Decembe	r 31 of the cost reportin	ng period (line	0	24.0
	r line 19) ng-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	ine 20)	31 of the cost reporting	perrou (Trile 8	U	25.00
26. 00 Tot	al swing-bed cost (see instructions)			0	26.00
	neral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 846, 801	27.0
	VATE ROOM DIFFERENTIAL ADJUSTMENT	Landa de la landa		0	00.0
	neral inpatient routine service charges (excluding swing-be vate room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	
	ni-private room charges (excluding swing-bed charges)			0	30.0
	neral inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
1	erage private room per diem charge (line 29 ÷ line 3)	•		0.00	32.0
1	erage semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
	erage per diem private room charge differential (line 32 mi		ti ons)	0.00	
1	erage per diem private room cost differential (line 34 x li vate room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 0 36. 0
1	neral inpatient routine service cost net of swing-bed cost	and private room cost dit	fferential (line	6, 846, 801	37.0
	minus line 36)				] 5
PAR <sup>*</sup>	T II - HOSPITAL AND SUBPROVIDERS ONLY		,		
	GRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1		
, ,	usted general inpatient routine service cost per diem (see	•		879. 37	
	ogram general inpatient routine service cost (line 9 x line Hically necessary private room cost applicable to the Progr			4, 168, 214 0	
	al Program general inpatient routine service cost (line 39	,		4, 168, 214	
23   . 30		,	1	., .00, 211	

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2019	Worksheet D-1		
			Component		Γο 12/31/2019			
			Title	e XVIII	Subprovi der -	6/25/2020 8: 0 PPS	<u>s alli</u>	
	Cost Contar Doscription	Total	Total	Average Per	IRF Program Days	Drogram Cost		
	Cost Center Description	Inpati ent	Inpatient	Di em (col. 1	Program bays	Program Cost (col. 3 x		
		Cost	Days	÷ col . 2)		col . 4)		
42. 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3.00	4.00	5. 00	42. 00	
42.00	Intensive Care Type Inpatient Hospital Units	0		η	<u> </u>	0	42.00	
43.00	INTENSIVE CARE UNIT	0	(		1	0	43.00	
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	(	0.00	0	0	43. 01 44. 00	
45. 00	BURN INTENSIVE CARE UNIT						45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00	
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00	
	cost center bescription					1. 00		
	Program inpatient ancillary service cost (Wk					2, 495, 256	1	
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		6, 663, 470	49. 00	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	419, 348	50.00	
F1 00		-+!+!!!-		W+ D -	£ Dt- 11	1// 407	F1 00	
51. 00	Pass through costs applicable to Program inpand IV)	attent ancilia	ry services (i	rom wkst. D, S	sum or Parts II	166, 427	51.00	
52.00	Total Program excludable cost (sum of lines					585, 775	52.00	
53.00	Total Program inpatient operating cost exclu	9 1	elated, non-ph	ysician anesth	etist, and	6, 077, 695	53.00	
	medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges					0	54.00	
55.00	Target amount per discharge					0.00	1	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	56. 00 57. 00	
58. 00	Bonus payment (see instructions)	9	g (			0	58.00	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00	
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market basket		0.00	60.00	
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of		0	61.00	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	0	62. 00					
63.00	Allowable Inpatient cost plus incentive payments	ent (see instr	uctions)			0	63.00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of th	a cast raparti	ng port od (Soo	0	64.00	
04.00	instructions)(title XVIII only)	ts through beco	elliber 31 of th	e cost reporti	ing period (see	O	04.00	
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65.00	
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	65)(title XVII	Lonly) For	0	66. 00	
00.00	CAH (see instructions)	ne costs (Time	or prus rine	00)((( (( 0 )	1 0111 47. 101	· ·	00.00	
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost re	porting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost repo	orting period	0	68. 00	
	(line 13 x line 20)					_		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00	
70.00	Skilled nursing facility/other nursing facil						70.00	
71.00	Adjusted general inpatient routine service of		line 70 ÷ line	2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 14 x l	ine 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine serv		•				74.00	
75. 00	Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B, F	Part II, column		75. 00	
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00	Program capital-related costs (line 9 x line	76)					77. 00	
78. 00	Inpatient routine service cost (line 74 minus		78.00					
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa		79. 00 80. 00					
81.00	On Inpatient routine service cost per diem limitation							
82.00								
83. 00 84. 00	Program inpatient ancillary services (see in:		113)				83. 00 84. 00	
85.00	Utilization review - physician compensation	(see instructi					85. 00	
86. 00	Total Program inpatient operating costs (sum		hrough 85)				86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27				0.00	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions	)		l	0	89. 00	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-T002	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
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	688, 800	6, 846, 801	0. 10060	02	0	90.00
91.00 Nursing School cost	0	6, 846, 801	0. 00000	00	0	91.00
92.00 Allied health cost	0	6, 846, 801	0. 00000	00	0	92.00
93.00 All other Medical Education	0	6, 846, 801	0. 00000	00	0	93.00

Heal th	Financial Systems METH	HODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and s	wing had days avaluding nawharm)		84, 762	1.00
2. 00	Inpatient days (including private room days, excl			84, 762	
3. 00	Private room days (excluding swing-bed and observ		nrivato room days	04, 702	
3.00	do not complete this line.	ation bed days). If you have only	private room days,	0	3.00
4. 00	Semi -private room days (excluding swing-bed and c	observation bed days)		64, 992	4.00
5. 00	Total swing-bed SNF type inpatient days (including		ber 31 of the cost		
	reporting period	g p			
6.00	Total swing-bed SNF type inpatient days (including	ng private room days) after Decembe	r 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on th	is line)			
7.00	Total swing-bed NF type inpatient days (including	, private room days) through Decemb	er 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including		31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on th			. 7/0	
9. 00	Total inpatient days including private room days	applicable to the Program (excludi	ng swing-bed and	2, 762	9.00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to t	itle VVIII only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period		1 00111 days)	0	10.00
11 00	Swing-bed SNF type inpatient days applicable to t		room days) after	0	11.00
00	December 31 of the cost reporting period (if cale		. com dayo, ar tor	Ŭ	
12.00	Swing-bed NF type inpatient days applicable to ti		ate room days)	0	12.00
	through December 31 of the cost reporting period	3 ( 3 )	,		
13.00	Swing-bed NF type inpatient days applicable to ti			0	13.00
	after December 31 of the cost reporting period (i	f calendar year, enter 0 on this I	i ne)		

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	84, 762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	84, 762	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	64, 992	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
7.00	report in g peri od	ĭ	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		l
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 762	9. 00
	newborn days) (see instructions)		1
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)		11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	٥	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	-	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	o	14.00
15.00	Total nursery days (title V or XIX only)	2, 632	15.00
16.00	Nursery days (title V or XIX only)	381	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
17.00	reporting period	0.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	73, 514, 433	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 4	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	x line 20)	٥	25.00
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	73, 514, 433	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,,	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	1
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	73 514 433	36. 00 37. 00
37.00	27 minus line 36)	73, 514, 433	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	867. 30	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 395, 483	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 395, 483	41.00

	Financial Systems	METHODI ST HOSI				u of Form CMS-2		
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co	Provi der CCN: 15-0002   Peri od: From 01/01/2019		Worksheet D-1		
				-	Го 12/31/2019	Date/Time Pre 6/25/2020 8:0		
				e XIX	Hospi tal	Cost		
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x		
		Cost	Days	÷ col . 2)	4.00	col . 4)		
42.00	NURSERY (title V & XIX only)	1. 00 3, 435, 576	2. 00 2, 632	3. 00 1, 305. 3°	4. 00 1 381	5. 00 497, 323	42.00	
	Intensive Care Type Inpatient Hospital Units							
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	12, 306, 663 2, 621, 975	7, 574 2, 213			0		
44. 00	CORONARY CARE UNIT	2,021,773	2,213	1, 104. 0			44.00	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						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	3, line 200)			1. 00 3, 069, 610	48. 00	
49. 00				ons)		5, 962, 416	49. 00	
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	n of Parts I and	0	50.00	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (fi	rom Wkst. D, s	sum of Parts II	0	51.00	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alatad nan nba	voi oi on onco+h	ustist and	0		
55.00	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		егатей, поп-рп	ysi ci aii allesti	etist, and		33.00	
54.00	Program di scharges					0	54.00	
	Target amount per discharge Target amount (line 54 x line 55)					0.00		
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	line 56 minus	line 53)	0	57.00	
58.00	Bonus payment (see instructions)	norting noried	anding 1004	undated and a	mnounded by the	0.00	58. 00 59. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	enaring 1996, t	upuateu anu cc	ilipounded by the	0.00	59.00	
60.00	1				the emount by	0. 00 0	60. 00 61. 00	
61.00	00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62.00	Relief payment (see instructions)	0						
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00					
64. 00		ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line o	65)(title XVII	I only). For	0	66. 00	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 o	of the cost re	eporting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00	
70. 00	Skilled nursing facility/other nursing facil		•				70. 00	
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ine 35)			72. 00 73. 00	
74.00	Total Program general inpatient routine serv						74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)		e costs (from N	Worksheet B, F	art II, column		75.00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00	
78.00	10 Inpatient routine service cost (line 74 minus line 77)							
79. 00 80. 00								
81.00	Inpatient routine service cost per diem limi	tati on			,		81.00	
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82. 00 83. 00	
84.00								
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
50.00	PART IV - COMPUTATION OF OBSERVATION BED PAS:		Jugit 00)				33.00	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			19, 770 867. 30		
	Observation bed cost (line 87 x line 88) (se	•				17, 146, 521		

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	Cost	
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	6, 836, 028	73, 514, 433	0. 09298	9 17, 146, 521	1, 594, 438	90.00
91.00 Nursing School cost	0	73, 514, 433	0.00000	0 17, 146, 521	l ol	91.00
92.00 Allied health cost	0	73, 514, 433	0.00000	0 17, 146, 521	0	92.00
93.00 All other Medical Education	0	73, 514, 433	0.00000	0 17, 146, 521	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2019	Worksheet D-1
	Component CCN: 15-S002		
	Title XIX	Subprovi der -	Cost
		IPF	

			I PF		
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 016	1.00
2.00	Inpatient days (including private room days, excluding swing-be			3, 016	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	). IT you have only pr	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 016	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period	l	04 . 6 . 1	0	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	0	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl	ONS) v (including private r	oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		days) area	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	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 XIX	only (including privat	o room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar yea			U	13.00
14.00	Medically necessary private room days applicable to the Program	1.5	,	0	14.00
15.00	Total nursery days (title V or XIX only)			2, 632	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			381	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
17.00	reporting period	thi dagir becomber or or	1110 0031	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 310, 655	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line		22.00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
200	7 x line 19)	0. 0. the cost report.		· ·	200
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		2, 310, 655	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	·			
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	a lina 22) (aaa inatruo	+: ana)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	= : /		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	2, 310, 655	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			766. 13	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 3			0	39. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	` ,		0	40. 00 41. 00
41.00	Trotal Trogram general impatrent routine service cost (ITNE 39 +	11116 40)		U	41.00

Provider CDR 15-000   Resident Dr. 1 (10 m)   Provider CDR 15-000   Provider CDR 15-00	Heal th Fi	inancial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
Cost Center Description				Provi der (		Period: From 01/01/2019	Worksheet D-1 Date/Time Pre	pared:
Cost Center Description				Ti t	le XIX	•		o um
1.00		Cost Center Description	I npati ent	Inpatient	Diem (col. 1	Program Days	(col. 3 x	
Interest via Care Tuple Inpatt ent Despital Units   0   0   0.000   0   0.43.00   147.00	42.00 NI	HIDCEDY (+; +l o V & VIV only)		2.00	3.00		5. 00	42.00
	42.00 Nt	ntensive Care Type Inpatient Hospital Units	U <sub>I</sub>		<u>J</u> 0. 00	<u>J</u>	0	42.00
44.00   DORONARY CARE UNIT   45.00   DORONARY CARE UNIT   45.00   DORONARY CARE UNIT   45.00   DORONARY CARE UNIT   45.00   DORONARY CARE UNIT   46.00   DORONA	43.00	NTENSIVE CARE UNIT	- 1					
45.00   SURPA INTERSIVE CARE UNIT   46.00   SURPA CLARE CARE CARE CARE CARE CARE CARE CARE C			0	(	0.00	0	0	1
46.00   SURCICAL INTERSIVE CARE UNIT   46.00   TOTAL PROCEST ON   47.00								
Cost Center Description								
1.00	47. 00 0							47.00
Program inpati ent ancillary service cost (wist. D-3, col. 3, line 200)   0, 48, 00   Total Program inpatient costs (com of lines 41 through 48) (see instructions)   0, 49, 00   Total Program inpatient costs (com of lines 41 through 48) (see instructions)   0, 50, 00   Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50, 00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and 19)   0, 51, 00   Total Program excludable cost (sum of lines 50 and 51)   0, 52, 00   70, 10   Total Program excludable cost (sum of lines 50 and 51)   0, 52, 00   70, 10		Cost Center Description					1. 00	
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program Inpatient routine services (from West. D, sum of Parts I and 11)  51.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D, sum of Parts II 0 51.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D, sum of Parts II 0 51.00 Parts II 0 51.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D, sum of Parts II 0 51.00 Parts	48. 00 Pr	rogram inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)				48. 00
50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II of 51.00 National Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (file 49 minus line 52) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (file 49 minus line 52) 54.00 Program discharges 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 50) 59.00 Difference between adjusted inpatient process from prior operating period (minus line 59) 59.00 Difference between adjusted inpatient process instructions) 59.00 Difference between adjusted inpatient process instructions (line 50) of the market basket amount by old of the data process of line 50 minus line 50	_		41 through 48)(	see instructi	ons)		0	49.00
111)   Seas through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II   0 51.00 and IV)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs applicable cost (sum of lines 50 and 51)   Seas through costs (line 54 x line 55)   Seas through costs (lines 54 x line 55)   Seas through costs (lines 54 x 60)   Seas through costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 50), otherwise enter zero (see instructions)   Seas through costs (lines 54 x 60), or 1% of the target amount (line 50), otherwise enter zero (see instructions)   Seas through costs (lines 54 x 60), or 1% of the target amount (line 50), otherwise enter zero (see instructions)   Seas through costs (lines 54 x 60), or 1% of the target amount (line 50), otherwise enter zero (see instructions)   Seas through costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount period (line 53) or the season of 50 the amount to line 53 through lines 14 x 60 through l			atient routine	services (fro	nm Wkst D sum	of Parts I and	0	50.00
and IV)  10.00 Total Program excludable cost (sum of lines 50 and 51)  10.01 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and operating cost excluding capital related, non-physician anesthetist, and operating cost excluding capital related, non-physician anesthetist, and operating cost and target amount (some costs (line 4 pt. 16.5))  10.02 Program discharges  10.03 Formal discharges  10.04 Cost of lines 34 x line 55)  10.05 Cost of lines 35 254 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket of lines 53/54 or 55 from prior year cost report, updated by the narket basket of lines 53/54 is less than the lower of lines 55, 59 or 40 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  10.02 Relief payment (see instructions)  10.03 Cost of lines 53/54 or 55 from prior year cost report, updated by the market basket of lines 55, 59 or 40 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  10.03 Cost of lines 53/54 is less than the lower of lines 55, 59 or 40 enter the lesser of 50% of the amount by which operating to soft (line 56), otherwise enter zero (see instructions)  10.03 Cost of lines 53/54 is less than the lower of lines 55, 59 or 40 enter the lesser of 50% of the amount by which operating costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  10.03 Cost of lines 54 x 60), or 1% of the cost reporting period (see lines of lines 55), or 60 enter the lesser of 50% of the amount by which operating costs (lines 64 x 60), or 1% of the cost reporting period (see linstructions)  10.04 Cost			attent routine	services (iii	JIII WKSt. D, Suii	i or raits i and	O	30.00
1		0	atient ancillar	y services (1	rom Wkst. D, s	sum of Parts II	0	51.00
Target mount per discharge   Sale			EO and E1)				0	E2 00
medical education costs (line 49 minus line 52)				lated, non-ph	nvsician anesth	netist, and		
54.00   Program discharges   0.0   54.00   55.00   Target amount per di scharge   0.00   55.00   Target amount per di scharge   0.00   55.00   Target amount (line 54 x line 55)   0.0   56.00   1   0.00   55.00   1   0.00   55.00   0.00	me	edical education costs (line 49 minus line						
55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bous payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise einstructions) 62.00 Reli ef payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) title truty line only of the cost instructions of the cost							0	E4 00
56.00   Target amount (line 54 x line 55)   0   56.00   57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00   58.00   Bonus payment (see instructions)   0   58.00   59.00   Loser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   60.00   Loser of lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   61.00   If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   0   61.00   62.00   Relief payment (see instructions)   0   63.00   63.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only).   65.00   64.00   Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tile XVIII only).   67.00   67.00   Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only).   67.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tile XVIII only).   67.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period   68.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period   68.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period   68.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 69)   69.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs (line 67 + line 69)   69.00   67.00   Tile V or XIX swing-bed NF inpatient routine costs (line 70 + line 69)   69.00   67.00   Tile V or XIX swing-bed NF inpatient routine service costs (line 70 + line 69)   69.00   67.00   Ti								
58.00   Bonus payment (see instructions)   58.00	56. 00 Ta	arget amount (line 54 x line 55)						56.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the analyte basket of the market basket of the market basket of the market basket of the market basket of the mount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) of 62.00 Relief payment (see instructions) of 63.00 All owable Inpatient cost plus incentive payment (see instructions) of 63.00 All owable Inpatient cost plus incentive payment (see instructions) of 63.00 All owable Inpatient cost plus incentive payment (see instructions) of 64.00 Market and the following the market payment (see instructions) of 64.00 Market are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) of 65.00 Market (see instructions) (title XVIII only) of 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) of 66.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) of 66.00 Total Hedicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) of 66.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68) of 69.00 Total title v or XIX swing-bed NF inpatient routine scots (line 67 + line 68) of 69.00 Total title v or XIX swing-bed NF inpatient routine scots (line 67 + line 2) of 69.00 Total title v or XIX swing-bed NF inpatient routine service costs (line 70 + line 2) of 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) of 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) of 73.00 Medically necessary private room cost applicable to Program (line 70 + line 2) of 73.00 Me	1	, , ,	ing cost and ta	irget amount (	(line 56 minus	line 53)		1
market basket   0.00   Loses of   lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   lf line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by   0   61.00   which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target   amount (line 56), otherwise enter zero (see instructions)   0   62.00   RoGARM INPATIENT ROUTINE SUNG BED COST   0   ROGARM INPA			norting period	endina 1996	undated and co	mnounded by the	-	
1.00   If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   0   62.00			por tring perrou	charing 1770,	apaarea ana ee	inpounded by the	0.00	37.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  0								
amount (I ine 56), otherwise enter zero (see instructions)  62.00  83.00  Allowable Inpatient cost plus incentive payment (see instructions)  64.00  Modificate Swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00  Modificate Swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only)  67.00  Modificate Swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  68.00  Modificate Swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-Bed NF inpatient routine costs (line 67 + line 68)  Modificate Swing-Bed NF inpatient routine costs (line 70 + line 2)  Modificate Swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient swing-Bed NF inpatient swing-Bed NF inpatient swing-Bed NF inpatient routine service cost (line 70 + line 2)  Modificate Swing-Bed NF inpatient swing-Bed NF inpatient swing-Bed NF inpat							0	61.00
Allowable Inpatient cost plus incentive payment (see instructions)   PROREMAL INPATIENT ROUTINE SUNING BED COST				.3 (111103 04 7	( 00), 01 1% 01	the target		
PROGRAM INPATIENT ROUTINE SWING BED COST							-	
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  60 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  73.00 Per diem capital -related costs (line 9 x line 76)  74.00 Per diem capital -related costs (line 9 x line 76)  75.00 Per diem capital -related costs (line 9 x line 76)  76.00 Program capital -related costs (line 9 x line 76)  77.00 Program capital related costs (line 9 x line 76)  78.00 Inpatient routine service cost from period (line 81)  80.00 Total Program routine service cost (line 9 x line 76)  81.00 Inpatient routine service cost (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service cost (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Deogram inpatient routine service cost (see instructions)			ent (see instru	icti ons)			0	63.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26. line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Porgram capital-related costs (line 75 + line 2) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost (line 74 minus line 77) 78.00 Reasonable inpatient routine service cost (from provider records) 78.00 Inpatient routine service cost (see instructions) 80.00 Inpatient routine service cost (see instructions) 81.00 Program inpatient ancillary service sce instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Willization review - physician compensation (see instructions) 84.00 Program inpatient ancillary service sce instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PA			ts through Dece	ember 31 of th	ne cost reporti	ng period (See	0	64.00
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Adjusted general inpatient routine service costs (line 70 + line 2)  72.00 Program routine service cost (line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs (see instructions)  81.00 Inpatient routine service costs (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 Willization review - physician compensation (see instructions)  84.00 Program inpatient accillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient routine cost yee diem (line 27 + line 2)  87.00 Total Program inpatient routine cost yee diem		, ,					_	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost per diem limitation 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Race in patient routine cost per diem (line 27 + line 2) 87.00 Race in patient routine cost per diem (line 27 + line 2) 87.00 Race			ts after Decemb	er 31 of the	cost reporting	j period (See	0	65.00
CAH (see instructions)  67.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0   69.00    PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00   Skilled nursing facility/other nursing facility/ICT/ID routine service cost (line 37)   70.00   71.00   Adjusted general inpatient routine service cost per diem (line 70 + line 2)   71.00   72.00   Program routine service cost (line 9 x line 71)   72.00   73.00   Medically necessary private room cost applicable to Program (line 14 x line 35)   73.00   74.00   75.00	66. 00 To	otal Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  70.00 Program routine service cost (line 9 x line 71)  70.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  70.00 Total Program general inpatient routine service costs (line 72 + line 73)  70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  70.00 Per diem capital -related costs (line 75 ÷ line 2)  70.00 Program copital -related costs (line 75 ÷ line 2)  70.00 Program general inpatient routine service costs (from provider records)  70.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.00 Inpatient routine service cost (line 74 minus line 77)  70.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Reasonable inpatient routine service (sost (see instructions)  80.00 Reasonable inpatient ancillary services (see instructions)  80.00 Program inpatient ancillary services (see instructions)  80.00 Total Program inpatient operating costs (sum of lines 83 through 85)  80.00 Total Program inpatient operating costs (sum of lines 83 through 85)  80.00 Total observation bed days (see instructions)  80.00 Total observation bed general inpatient routine cost per diem (line 27 + line 2)  80.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  80.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	CA	AH (see instructions)						
68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		9 1	e costs through	December 31	or the cost re	eporting period	0	67.00
69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70. 00 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81. 00 Reasonable inpatient routine service costs (see instructions) 82. 00 Reasonable inpatient ancillary services (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 84. 00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 9. 00 88. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 9. 00 88. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 9. 00 88. 00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 9. 00 88. 00	,	•	e costs after D	ecember 31 of	the cost repo	orting period	0	68.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/lof/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital - related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital - related costs (line 75 + line 2)  77.00 Program capital - related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)			routing goots (	lino 47 i lin	20 (0)		0	40.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 ÷ line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0	09.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	70. 00 SI	killed nursing facility/other nursing facil	ity/ICF/IID rou	itine service	cost (line 37)			
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				ine 70 ÷ line	2)			
Total Program general inpatient routine service costs (line 72 + line 73)  74.00 75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1 Inpatient routine service cost per diem limitation  Inpatient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)  81.00  Reasonable inpatient routine service costs (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  74.00  75.00  76.00  76.00  77.00  76.00  77.00  77.00  78.00  77.00  78.00  79.00  80.00  10 Inpatient routine service costs (from provider records)  79.00  80	1			ı (line 14 x I	ine 35)			
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00								
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Oscillation (line 9 x line 80) 87.00 Oscillation (line 9 x line 81) 87.00 Oscillation (line 9 x line 81) 88.00 Adjusted general inpatient operation (see instructions) 89.00 Oscillation (line 9 x line 81) 89.00 Oscillation (line 78 minus line 79) 89.00 Oscillation (line 78 minus lin			routine service	costs (from	Worksheet B, F	Part II, column		75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00	1		ne 2)					76 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  80.00  80.00  80.00  80.00  80.00  80.00	1	·						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80.00 80.00	1	•						
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Security 100 Secu	١,	00 0			*.	nus line 79)		
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 Reasonable inpatient routine service costs (see instructions)  80.00 Reasonable inpatient routine service costs (see instructions)  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine services (see instructions)  85.00 Reasonable inpatient routine services (see instructions)  85.00 Reasonable inpatient routine services (see instructions)  85.00 Reasonable inpatient routine services (see instructions)  86.00 Reasonable inpatient routine services (see instructions)  87.00 Reasonable inpatient routine services (see instructions)  88.00 Reasonable inpatient routine services (see instructions)  89.00 Reasonable inpatient routine services (see instructions)	1	•			(	, ,		
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00 Reservation bed days (see instructions)  80.00 Reservation bed days (see instructions)	1							
85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1	•		15)				
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1	•		ns)				1
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  0.00 88.00	86. 00 To	otal Program inpatient operating costs (sum	of lines 83 th					86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00							Ω	87 00
				line 2)				
	89. 00 Ob	bservation bed cost (line 87 x line 88) (se	e instructions)				0	89.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2019 To 12/31/2019		
			e XIX	Subprovi der - I PF	Cost	
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	103, 008	2, 310, 655	0. 04458	0 0	0	90.00
91.00 Nursing School cost	0	2, 310, 655	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 310, 655	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 310, 655	0.00000	0 0	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2019	Worksheet D-1
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		I RF	

			IR	F		
INPATTER IMPS   INPATTER IMPS   INPATTER IMPS   InpatTent days (Including private room days, and saling bed days, excluding newborn)   7,766   1.00		Cost Center Description		$\vdash$	1 00	
INPARTENT MAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days, excluding saring-bed and newborn days)   7,786   2,00		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days.   0   3.00						
do not complete this line.  4. 00 Sein-j-relate room days (excluding swing-bed and observation bed days)  7. 7.66    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 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) through 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. 00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and nextorm days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through 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 through December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  14. 00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  15. 00 Total Injury of the Cost reporting period (if calendar year, enter 0 on this line)  16. 00 New Year (and the type title Year XIX only)  17. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  18. 00 New Year (and the Year XIX only)  18. 00 New Year (and Year Year Ye				om dave		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost on the cost reporting period of the cost reporting period (if callendar 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 callendar 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 callendar year, enter 0 on this line)  9.01 Total inpatient days including private room days after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10.02 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  11.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and proper type period (if callendar year, enter 0 on this line)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) attained the cost proper days (it line) and the cost reporting period (if callendar year, enter 0 on this line)  14.00 Total nursery days (it line vor XX only)  15.00 Nursery days (it line vor XX only)  16.00 Nursery days (it line vor XX only)  17.00 Medicane rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including peri	3. 00		ys). It you have only private roo	m days,	J	3.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 Total inpation (if calendar year, enter 0 on this line) 8.00 Total inpation days (including private room days) after December 31 of the cost 7.00 Total inpation days) (including private room days) after December 31 of the cost 7.00 Total inpation days) (see instructions) 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and 7.00 newborn days) (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 through December 31 of the cost reporting period (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed WF type services ap					7, 786	
Total swing-bad SNF type inpatient days (including private room days) after December 31 of the cost	5. 00		om days) through December 31 of t	the cost	0	5. 00
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 to the private room days after December 31 of the cost on the strong of the	6. 00		om davs) after December 31 of the	e cost	0	6. 00
reporting period  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. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 139 9.00 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 0 becomes 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 becomes 31 of the cost reporting period (see instructions)  13. 00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) of 12.00 through December 31 of the cost reporting period (including period (including private room days) of 12.00 through December 31 of the cost reporting period (including period room days) of 12.00 through December 31 of the cost reporting period (including swing-bed days) of 12.00 through December 31 of the cost reporting period (including swing-bed days) of 12.00 through December 31 of the cost reporting period (including swing-bed days) of 12.00 through December 31 of the cost (including swing-bed SNF services applicable to services through December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services after December 31 of the cost (including swing-bed SNF services after December 31 of the cost (including swing-bed SNF services after December 31 of the cost reporting period (including swing-bed SNF services after December 31 of the cost reporting period (including swing-bed SNF services after December 31 of th		reporting period (if calendar year, enter 0 on this line)				
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line)   9,00	7. 00		m days) through December 31 of th	ne cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)  10.00 for 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 through 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 private proom the private proom days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  14.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nedically necessary private room days applicable to services through December 31 of the cost  17.00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost  18.00 Nedical dar fate for swing-bed NF services applicable to services after December 31 of the cost  18.00 Nedical dar fate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of the private room cost applicable	8. 00		m days) after December 31 of the	cost	0	8. 00
newborn days) (see instructions)   0   10   00   00   10   00   00   10   00   00   10   00   00   10   00   00   10   00   10   00   10   00   10   00   10   00   10   00   10   00   10			,			
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 (if calendar year, enter 0 on this line) 12.00 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) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.01 Nursery days (title V or XIX only) 18.02 Nursery days (title V or XIX only) 19.03 Nursery days (title V or XIX only) 19.04 Nursery days (title V or XIX only) 19.05 Nursery days (title V or XIX only) 19.06 Card rate for swing-bed SNF services applicable to services through December 31 of the cost on the cost of th	9. 00		o the Program (excluding swing-be	ed and	139	9. 00
through 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 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 Dedical in processary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  15.00 Total nursery days (title V or XIX only)  15.00 No Interpret days (title V or XIX only)  16.00 Neuropry days (title V or XIX only)  17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost one reporting period  18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period  19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period  20.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost one reporting period one period of the cost	10 00		nlv (including private room days)	)	0	10 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00   Swing-bed NF type inpatient days applicable to titles \( \tilde{V} \) or XIX only (including private room days)   0   12.00	11. 00			after	0	11.00
through December 31 of the cost reporting period  13.00 Sing-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 the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  15.00 Total nursery days (title V or XIX only)  16.00 Nervery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 New ISED ADJUSTMENT  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Nerver reporting period  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 New ISED ADJUSTMENT  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nerver reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nerver reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 New Ised and the forest swing-bed NF services applicable to services after December 31 of the cost  20.00 New Ised and the forest swing-bed NF services applicable to services after December 31 of the cost  20.00 New Ised and the forest swing-bed NF services applicable to services after December 31 of the cost reporting period (line only the cost is in the c	12 00			ave)	0	12 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00  15. 00  16. 10 Total nursery days (title V or XIX only)  16. 00  17. 00  18. 00  18. 00  19.	12.00	3 31 1 3 11	X only (Therading private room at	193)	J	12.00
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   Nursery days (title V or XIX only)   381   16.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   19.00	13.00			ays)	0	13.00
15.00   Total nursery days (title V or XIX only)   381   16.00	14 00				0	14 00
16. 00   Nursery days (title v or XIX only)   381   16. 00   00   00   00   00   00   00   00			all (excluding swing-bed days)			
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Nedicare rate for swing-bed SNF type services through December 31 of the cost reporting period (19.00 Nedicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00 Nedicare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19.00 Nedicare rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19.00 Nedicare rate for swing-bed cost applicable rate for swing-bed cost applicable rate for swing-bed cost and private room cost differential (19.00 Nedicare rate for swing-bed cost and private room cost differential (1						
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 1.00 Total general inpatient routine service cost (see instructions) 6.846,801 21.00 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 SNF type services through December 31 of the cost reporting period (line 0 23.00 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 0 25.00 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6, 846, 801 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Average private room per diem charge (line 29 * line 3) 31.00 General inpatient routine service cost charge ratio (line 27 * line 28) 0.00000 31.00 General inpatient routine service cost charges (and unit in 32 minus line 33) (see instructions) 0.00 32.00 33.00 Average per diem private room charge (line 29 * line 3) 0.00000 33.00 Average per diem private room cost differential (line 3 x line 35) 0.0000 35.00 Average per diem private room cost differential (line 3 x line 35) 0.0000 35.00 Average per diem private room cost differential (line 3 x line 35) 0.0000 Proyram general inpatient routine service cost per diem (see	17.00		thursumb December 21 of the con-		0.00	17.00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17.00		es through December 31 of the cos	š t	0.00	17.00
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	18.00		es after December 31 of the cost		0. 00	18.00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00)  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 of x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of 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)  28.00 PRIVATE ROWD DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  31.00 General inpatient routine service cost (line 21 minus line 33) (see instructions)  32.00 Average per diem private room cost differential (line 3 x line 31)  33.00 Average per diem private room cost differential (line 3 x line 31)  34.00 Foreign and private room cost differential (line 3 x line 35)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost (repost Assimal)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)	10.00		o through Docombon 21 of the coot		0.00	10.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  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 through December 31 of the cost reporting period (line 7 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Average private room per diem charge (line 29 + line 3)  30.00 Semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  37.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  38.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room charge differential (line 34 x line 31)  39.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room charge differential (line 32 minus line 33)  39.00 Average per diem private room cost differential (line 32 minus line 33)  39.00 Average per diem private room c	19.00		s through beceimer 31 of the cost	•	0.00	19.00
21.00 Total general inpatient routine service cost (see instructions)  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 through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  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)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 x line 31)  35.00 Private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 31)  38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the cost		0. 00	20.00
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 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)  27.00 Part Inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service 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 semi-private room per diem charge (line 29 * line 4)  30.00 Average per diem private room cost differential (line 30 * line 4)  30.00 Average per dem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential	21. 00	' " "	s)		6, 846, 801	21. 00
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 X line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 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)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charges (line 29 + line 3)  30.00 Average per diem private room charge differential (line 32 minus line 23)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 846, 801)  37.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  39.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 846, 801)  37.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (per diem (see instructions)  30.00 Average general inpatient routine service cost (per line 38)  30.00 Average general inpatient routine service cost (per line 38)  30.00 Average general inpatient routine service cost (per line 38)  30.00 Average general inpatient routine service cost (per line 38)  30.00 Average general inpatient routine service cost (per line 38)  30.00 Average general inpatien				od (line		
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 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6, 846, 801 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charge (line 27 + line 28) 0 0.00 33.00 Semi-private room per diem charge (line 30 + line 3) 0 0.00 33.00 Semi-private room cost differential (line 32 minus line 33)(see instructions) 0.00 34.00 Semi-private room cost differential (line 3 x line 31) 0 0.00 35.00 Semi-private room cost differential diem service cost net of swing-bed cost and private room cost differential (line 6, 846, 801 37.00 Program general inpatient routine service cost per diem (see instructions) 1 29.00 Semi-private room cost applicable to the Program (line 14 x line 35) 1 22.232 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1 40.00 Medically necessary private room cost	22.00	/	21 of the cost reporting period	(line (	0	22.00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	23.00		31 of the cost reporting period	(TITIE 0	U	23.00
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)  Coeneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service 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 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charged differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 4,846,801)  30.00 Adjusted general inpatient routine service cost (line 9 x line 38)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		r 31 of the cost reporting period	d (line	0	24.00
x line 20)  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)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service 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)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 846, 801)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (cost (cline 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26.00 General cost (cline 9 x line 38)  26.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00	/	31 of the cost reporting period (	(line 8	0	25. 00
27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   6,846,801   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   29. 00     29. 00   Pri vate room charges (excluding swing-bed charges)   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 pri vate room per diem charge (line 29 + line 3)   0.00     33. 00   Average semi-pri vate room per diem charge (line 30 ± line 4)   0.00     33. 00   Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)   0.00   34. 00     34. 00   Average per diem pri vate room cost differential (line 34 x line 31)   0.00   35. 00     35. 00   Average per diem pri vate room cost differential (line 34 x line 35)   0   36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   879. 37   38. 00     39. 00   Program general inpatient routine service cost per diem (see instructions)   122, 232   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00			or or one controlled broken			
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average pri vate room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 6, 846, 801)  38. 00 Ajusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  10 Average per diem pri vate room cost differential (line 9 x line 38)  10 Average per diem private room cost differential (line 6, 846, 801)  10 Average per diem private room cost differential (line 6, 846, 801)  11 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 6, 846, 801)  12 Average per diem private room cost differential (line 3 x line 33)  12 Average per diem private room cost differential		, ,	(1: 21 -: 1: 2()			
28.00 General inpatient routine service 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)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 846, 801)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  20.00  20.00  31.00  0.000003  32.00  32.0	27.00		(TITIE 21 IIIITIUS TITIE 26)		0, 840, 801	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 846, 801 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 000000 31.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.0	28. 00		d and observation bed charges)		0	28.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,846,801)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.000 000 32.00  0.000 33.00  0.000 34.00  0.000 34.00  0.000 34.00  0.000 35.00  0.000 36.00  0.0						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4,846,801)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32			: Line 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 846, 801)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 33.00  37.00 36.00  37.00 36.00  37.00 37.00  38.00 37.00			÷ 111le 20)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 846, 801)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  36.00 35.00  36.00 36.00  37.00 36.00  37.00 37.00  37.00 38.00  37.00 39.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00						
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 37.00  38.00 17.00  38.00 17.00  38.00 18.00  38.00 19.00  38.00 19.00  38.00 19.00  38.00 19.00  38.00 19.00			nus line 33)(see instructions)	İ		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 A, 846, 801	35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  879.37 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  879.37 38.00  Program general inpatient routine service cost (line 9 x line 38)  122,232 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00	,	and private room cost differentia	al (line	6, 846, 801	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  879.37 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  879.37 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 122,232 39.00 40.00	38. 00				879. 37	38.00
	39. 00	, , , , , , , , , , , , , , , , , , , ,	· ·			
41.00   Total Program general inpatient routine service cost (line 39 + line 40)		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	liotal Program general inpatient routine service cost (line 39	+ IINE 4U)	I	122, 232	41.00

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	METHODI ST HOSE		CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component	CCN: 15-T002	From 01/01/2019 To 12/31/2019		
			Ti tl	e XIX	Subprovi der -	6/25/2020 8:0 Cost	03 am
	Cost Center Description	Total Inpatient	Total Inpatient	Average Pe Diem (col.	9	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2. 00 C	3.00	4. 00 00 0	5.00	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	C	0	00 0	0	43.00
43.01	NEONATAL ICU	Ö	C		00 0		43. 01
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk.			one)		71, 698	
49. 00	Total Program inpatient costs (sum of lines : PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see mstructi	ons)		193, 930	1 49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, s	um of Parts I and	0	50.00
51. 00		atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
	and IV)		,			_	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-ph	vsician anes	thetist and	0	
00.00	medical education costs (line 49 minus line		Tatea, non pri		thotrot, and		] 00.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
56.00	Target amount (line 54 x line 55)		/	li F/i	- 1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	iine so minu	STITIE 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the	0.00	
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market baske	t	0.00	60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% o	f the amount by	0	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1%	of the target		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost repor	ting period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reporti	na neriod (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XV	III only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost	reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost re	norting period	0	68.00
	(line 13 x line 20)				por tring period		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil				7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
73. 00	Medically necessary private room cost applications		(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv				5		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksneet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minus						77.00
79. 00	Aggregate charges to beneficiaries for excess		rovi der recor	ds)			79.00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		ost limitatio	n (line 78 m	inus line 79)		80.00
82.00	Inpatient routine service cost per drem frim		)				82.00
83.00	Reasonable inpatient routine service costs (	see instruction					83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ins)				84.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
97 OO	PART IV - COMPUTATION OF OBSERVATION BED PASS					0	87. OC
87. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			l	88.00
88.00	Aujusteu generar inpatrent routine cost per	ar cm (11110 27 .	11110 2)				

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component	CCN: 15-T002	From 01/01/2019 To 12/31/2019		
	Ti tl	e XIX	Subprovi der -	Cost		
				I RF		
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	
				, i	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	688, 800	6, 846, 801	0. 10060	0	0	90.00
91.00 Nursing School cost	0	6, 846, 801	0. 00000	00	0	91.00
92.00 Allied health cost	0	6, 846, 801	0. 00000	00	0	92.00
93.00 All other Medical Education	0	6, 846, 801	0. 00000	00	0	93. 00

NPATI ENT	F ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre 6/25/2020 8:0	pare
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3. 00	
I N	PATIENT ROUTINE SERVICE COST CENTERS		•			
0.00 03	000 ADULTS & PEDIATRICS			22, 714, 112		30.
1.00 03	100 INTENSIVE CARE UNIT			9, 810, 709		31.
	101 NEONATAL ICU			0		31.
	000 SUBPROVI DER - I PF			0		40.
	100 SUBPROVI DER - I RF			0		41.
	300 NURSERY					43
	CILLARY SERVICE COST CENTERS					ļ
	000 OPERATING ROOM		0. 10062		2, 252, 304	50
	001 ENDOSCOPY		0. 19686		304, 462	50
	100 RECOVERY ROOM		0. 25223		339, 558	
	200 DELIVERY ROOM & LABOR ROOM		1. 21324 0. 00000		34, 877 0	
	300  ANESTHESI OLOGY 400  RADI OLOGY-DI AGNOSTI C		0. 00000		896, 604	53 54
	400 RADI OLOGY - DI AGNOSTI C 401 RADI OLOGY - ULTRASOUND		0. 2002		252, 698	
	500 RADI OLOGY-THERAPEUTI C		0. 16176		66, 201	55
	501   NFUSION CENTER		0. 15042		00, 201	55
	600 RADI OI SOTOPE		0. 19998		445, 968	
	700 CT SCAN		0. 0376		671, 046	57
	800 MAGNETIC RESONANCE IMAGING (MRI)		0. 06259		303, 270	58
	900 CARDI AC CATHETERI ZATI ON		0. 08423		860, 136	
0.00 06	000 LABORATORY		0. 10128	35 21, 630, 168	2, 190, 812	60
. 01   06	001 BLOOD LABORATORY		0.00000	oo o	0	60
. 00 06	100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	00 0	0	61
. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2098	3, 597, 929	755, 051	62
	300 BLOOD STORING, PROCESSING & TRANS.		0.00000	00	0	63
	400 INTRAVENOUS THERAPY		0.00000	00	0	64
	500 RESPI RATORY THERAPY		0. 1175		1, 659, 370	
	600 PHYSI CAL THERAPY		0. 35824		611, 976	
	700 OCCUPATI ONAL THERAPY		0. 39653		433, 899	
	800 SPEECH PATHOLOGY		0. 31780		281, 564	68
	900 ELECTROCARDI OLOGY		0. 0565		326, 750	
4	901 CARDI AC REHAB		0.71623		203	
	000 ELECTROENCEPHALOGRAPHY		0. 07139		210, 656	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS		0. 34188		2, 878, 629	
	300 DRUGS CHARGED TO PATIENTS		0. 53550 0. 1700		2, 909, 727 5, 762, 245	
	400 RENAL DIALYSIS		0. 17006		1, 087, 001	74
	TPATIENT SERVICE COST CENTERS		0.31000	JO <sub>1</sub> J, 470, 730	1,007,001	′ <sup>→</sup>
00			0.2000	127 224	E2 E20	1

137, 234 6, 407, 953 3, 452, 088 179, 773, 906

179, 773, 906

53, 529

1, 829, 797 92. 00 29, 034, 496 200. 00

1, 616, 163

90.00

91.00

201. 00 202. 00

0. 390056

0. 252212

0. 530055

90. 00 09000 CLI NI C

201.00

202.00

91. 00 09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

NPATIENT AN			CN: 15-0002 CCN: 15-S002	Peri From To	od: n 01/01/2019 12/31/2019	Worksheet D-3 Date/Time Pre	
		<u> </u>				6/25/2020 8:0	
		litle	e XVIII	Sub	provi der – I PF	PPS	
	Cost Center Description		Ratio of Cos	st	I npati ent	I npati ent	
			To Charges		Program Charges	Program Costs (col. 1 x col. 2)	
			1.00		2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS		ı		ام		1 20 6
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT				0		30.0
	NEONATAL I CU				0		31. (
	SUBPROVI DER - I PF				2, 258, 665		40.0
	SUBPROVI DER - I RF				2, 230, 003		41.0
	NURSERY				Ğ		43. (
	LARY SERVICE COST CENTERS						
	OPERATING ROOM		0. 1006		0	0	
	ENDOSCOPY		0. 1968		0	0	
	RECOVERY ROOM		0. 2522		0	0	
2.00 05200	DELIVERY ROOM & LABOR ROOM		1. 2132		0	0	1
	ANESTHESI OLOGY		0.0000		0	0	
	RADI OLOGY - JULTPASCUND		0. 2082		19, 661	4, 095	1
	RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C		0. 1545 0. 1617		12, 946 0	2, 001 0	1
	INFUSION CENTER		0. 1517		0	0	1
	RADI OI SOTOPE		0. 1999		2, 083	417	1
	CT SCAN		0. 0376		56, 361	2, 120	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 0625		21, 601	1, 352	
	CARDI AC CATHETERI ZATI ON		0. 0842		12, 023	1, 013	
06000	LABORATORY		0. 1012	85	200, 627	20, 321	60.
	BLOOD LABORATORY		0.0000		0	0	60.
	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	0	
	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2098		16, 696	3, 504	
	BLOOD STORING, PROCESSING & TRANS.		0.0000		0	0	
	I NTRAVENOUS THERAPY		0.0000		0	0	
	RESPI RATORY THERAPY PHYSI CAL THERAPY		0. 1175		4, 233 2, 902	498	
	OCCUPATIONAL THERAPY		0. 3582 0. 3965			1, 040 574	1
	SPEECH PATHOLOGY		0. 3965		1, 448	0	
	ELECTROCARDI OLOGY		0. 0565		47, 368	2, 677	
	CARDI AC REHAB		0. 7162		47, 300	2,077	1
	ELECTROENCEPHALOGRAPHY		0. 0713		2, 085	149	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3418		9, 395	3, 212	
	IMPL. DEV. CHARGED TO PATIENTS		0. 5355		1, 986	1, 064	
3.00 07300	DRUGS CHARGED TO PATIENTS		0. 1700	61	539, 721	91, 785	73.
4.00 07400	RENAL DIALYSIS		0. 3106	66	0	0	74.
	TIENT SERVICE COST CENTERS		1				١
	CLINIC		0. 3900		0	0	
	EMERGENCY  OBSERVATION REDS (MON DISTINCT DART)		0. 2522		35, 996	9, 079	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 5300	55	007 100	144 001	
00.00	Total (sum of lines 50 through 94 and 96 through 98)	(line (1)			987, 132	144, 901	1
01.00	Less PBP Clinic Laboratory Services-Program only charges	(TIME 61)	I	- 1	OI		201.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0002	Period: From 01/01/2019	Worksheet D-3	
	Component	CCN: 15-T002	To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
	Titl€	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3.00	
I NPATIENT ROUTINE SERVICE COST CENTERS  0.00 O3000 ADULTS & PEDIATRICS			400	I	1 20 0
D. 00  03000 ADULTS & PEDIATRICS 1.00  03100 INTENSIVE CARE UNIT			409		30.00
1. 00   03100  TNTENSTVE CARE UNIT					31.0
0. 00   04000   SUBPROVI DER - 1 PF			0		40.00
1. 00   04100   SUBPROVI DER -   I RF			4, 446, 528		41.0
3. 00 04300 NURSERY			1, 110, 020		43.0
ANCILLARY SERVICE COST CENTERS					
D. 00   05000   OPERATING ROOM		0. 10062		19, 790	
D. 01   05001   ENDOSCOPY		0. 1968		2, 305	
1.00   05100   RECOVERY ROOM		0. 2522		3, 217	
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 2132		0	
3. 00 05300 ANESTHESI OLOGY		0.00000		0	
4. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 2082		24, 243	
4. O1  05401 RADIOLOGY - ULTRASOUND 5. OO  05500 RADIOLOGY-THERAPEUTIC		0. 1545 0. 1617		3, 789	
5. 01   05501   I NFUSI ON CENTER		0. 15176		7, 340 0	1
6. 00   05600   RADI OI SOTOPE		0. 1999		5, 142	
7. 00 05700 CT SCAN		0. 0376		13, 370	
B. OO O5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 06259		7, 945	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0842		5, 740	
D. 00   06000   LABORATORY		0. 10128		87, 251	
D. 01 06001 BLOOD LABORATORY		0.00000	00	0	60.0
1.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2098!		7, 899	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
4. 00   06400   I NTRAVENOUS THERAPY		0.0000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 1175		84, 112	
6. 00   06600   PHYSI CAL THERAPY 7. 00   06700   OCCUPATI ONAL THERAPY		0. 3582		745, 310	
7. 00   06700   0CCUPATIONAL THERAPY 3. 00   06800   SPEECH PATHOLOGY		0. 3965		743, 700 83, 160	
8. 00  06800 SPEECH PATHOLOGY 9. 00  06900 ELECTROCARDI OLOGY		0. 31780 0. 0565		2, 270	
9. 01   06901   CARDI AC   REHAB		0. 0363		2,270	1
D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 07139		1, 161	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3418		50, 535	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 53550		34, 846	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1700		454, 537	
4. 00 07400 RENAL DIALYSIS		0. 3106		104, 252	
OUTPAȚI ENT SERVI CE COST CENTERS					
D. 00   09000   CLI NI C		0. 3900!		282	
1. 00   09100   EMERGENCY		0. 2522		3, 060	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5300!		0	
DO.00 Total (sum of lines 50 through 94 and 96 through 98) D1.00 Less PBP Clinic Laboratory Services-Program only cha			10, 106, 293	2, 495, 256	200. 0 201. 0

Health Financial Systems	METHODIST HOSPITALS, INC			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	3
			From 01/01/2019 To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
	Ti tl	e XIX	Hospi tal	Cost	75 aiii
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	
I NPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			2, 614, 637		30.00
31. 00   03100   INTENSIVE CARE UNIT			578, 866		31.00
31. 01   03101   NEONATAL   CU			597, 120		31.01
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF			125, 025		40.00
43. 00   04300   NURSERY			128, 660 276, 505		43.00
ANCILLARY SERVICE COST CENTERS			270, 303		43.00
50. 00 05000 OPERATING ROOM		0. 10062	26 3, 025, 963	304, 491	50.00
50. 01   05001   ENDOSCOPY		0. 19686		26, 353	1
51. 00   05100 RECOVERY ROOM		0. 25223	· ·	39, 428	
52.00   05200   DELIVERY ROOM & LABOR ROOM		1. 21324		1, 002, 859	
53. 00   05300   ANESTHESI OLOGY		0.00000		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20827	72 303, 344	63, 178	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 15456	183, 914	28, 426	54.01
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 16176	33, 017	5, 341	55.00
55. 01   05501   I NFUSI ON CENTER		0. 15042		0	55. 01
56. 00   05600   RADI 01 SOTOPE		0. 19998		31, 332	
57. 00  05700   CT   SCAN		0. 03761		54, 338	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 06259		23, 627	
59. 00   05900   CARDI AC CATHETERI ZATI ON		0. 08423		83, 778	
60. 00   06000   LABORATORY		0. 10128		255, 962	
60. 01   06001   BLOOD LABORATORY		0.00000		0	
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0 460	
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 20985		9, 469 0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 00000		158, 120	
66. 00   06600   PHYSI CAL THERAPY		0. 11757		53, 975	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 39653		44, 400	
68. 00   06800   SPEECH PATHOLOGY		0. 31780		18, 619	
69. 00   06900   ELECTROCARDI OLOGY		0. 05651		21, 213	
69. 01   06901   CARDI AC   REHAB		0. 71623		5, 894	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 07139		14, 474	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 34188		0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 53550		0	
73 OO O7300 DRUGS CHARGED TO PATLENTS		0 17006		578 127	

0.170061

0. 310666

0. 390056

0. 252212

0. 530055

3, 399, 527

148, 683

20, 295

761, 657

16, 791, 028

16, 791, 028

0 3, 069, 610 200. 00

578, 127

46, 191

7, 916

192, 099

73.00

74.00

90.00

91.00

92.00

201. 00 202. 00

07300 DRUGS CHARGED TO PATIENTS

74.00

200.00

201.00

202.00

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	}
	Component	CCN: 15-T002	From 01/01/2019 To 12/31/2019		
	Ti tl	e XIX	Subprovi der -	Cost	75 all
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					4
00 03000 ADULTS & PEDIATRICS			0		30.
00   03100   I NTENSI VE CARE UNI T			0		31.
01 03101 NEONATAL ICU			0		31.
00   04000   SUBPROVI DER - I PF			0		40
00   04100   SUBPROVI DER - I RF			124, 800		41
00   04300   NURSERY			0		43
ANCILLARY SERVICE COST CENTERS		0.1007	2/ 1.002	100	4
00 05000 OPERATING ROOM		0. 1006	·	199	
01   05001   ENDOSCOPY 00   05100   RECOVERY   ROOM		0. 1968		0	
00   05100   RECOVERY ROOM		0. 2522		94 507	
00 05300 ANESTHESI OLOGY		1. 2132 0. 0000		0	
00   05400   RADI OLOGY - DI AGNOSTI C		1			
01   05401   RADI OLOGY - ULTRASOUND		0. 2082			
00   05500   RADI OLOGY - OLTRASOOND		0. 1545 0. 1617		160 0	
01   05501   NFUSI ON CENTER		0. 1517			
00   05600   RADI OI SOTOPE		0. 1304		77	
00   05700   CT   SCAN		0. 0376			
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0625		244	
00 05900 CARDI AC CATHETERI ZATI ON		0. 0842	·		
00 06000 LABORATORY		0. 1012			
01 06001 BLOOD LABORATORY		0.0000	·	0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2098			
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	·		
00 06400 I NTRAVENOUS THERAPY		0.0000		l o	
00 06500 RESPIRATORY THERAPY		0. 1175		2, 179	
00 06600 PHYSI CAL THERAPY		0. 3582	·	21, 208	
00 06700 OCCUPATI ONAL THERAPY		0. 3965	·	20, 315	
00 06800 SPEECH PATHOLOGY		0. 3178		3, 329	
00 06900 ELECTROCARDI OLOGY		0. 0565	· ·	23	
01 06901 CARDI AC REHAB		0. 7162		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 0713		9	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3418		697	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5355	03 83	44	72
00 07300 DRUGS CHARGED TO PATIENTS		0. 1700	61 108, 278	18, 414	73
00 07400 RENAL DIALYSIS		0. 3106	66 3, 821	1, 187	<b>_</b> 74
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLI NI C		0. 3900	56 0	0	90
00 09100 EMERGENCY		0. 2522	12 0	0	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5300	55 0	0	92
Total (sum of lines 50 through 94 and 96 through 98)			290, 695	71, 698	200
.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201
Net charges (line 200 minus line 201)		I	290, 695	I	202

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/25/2020 8:03 am

			To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see	0 29, 362, 547	1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurr instructions)</pre>	ing on or after October	1 (see	9, 963, 704	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2. 01 2. 02
2. 03	Outlier payments for discharges occurring prior to October 1	•		1, 084, 459	2. 03
2. 04	Outlier payments for discharges occurring on or after October	1 (see instructions)		195, 924	2.04
3.00	Managed Care Simulated Payments			19, 735, 495	3.00
4. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	ictions)	383. 00	4.00
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	8. 53	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7. 00 7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slunder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	see	8. 53	9. 00
10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	ds	3.00	
11.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
	Total allowable FTE count for the prior year.				13.00
14. 00	Total allowable FTE count for the penultimate year if that ye	ar ended on or after Sep	tember 30, 1997,	2. 93	ı
	otherwise enter zero.	·			
	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo	CUEO		0.00	16. 00 17. 00
	Adjusted rolling average FTE count	sui e		2. 98	1
	Current year resident to bed ratio (line 18 divided by line 4	).		0. 007781	1
20.00	Prior year resident to bed ratio (see instructions)			0. 007527	20.00
	Enter the lesser of lines 19 or 20 (see instructions)			0. 007527	ł
	IME payment adjustment (see instructions)			161, 513	1
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42.	2 of the MMA		81, 054	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resid		FR 412. 105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			-5. 53	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0. 00	
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
27. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0.000000	27. 00 28. 00
	IME add-on adjustment amount - Managed Care (see instructions	)		0	28. 01
	Total IME payment ( sum of lines 22 and 28)	,		161, 513	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment			81, 054	
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ti ons)	8. 39	1
	Percentage of Medicaid patient days (see instructions)			32. 28	1
	Sum of lines 30 and 31	)		40. 67 22. 77	1
	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	)		22. 77 2, 238, 647	1
5 55	12. 2p. 2p2. 3. 3. at 3 3. at 3 at an at a and a standing (300 1113th actions)		ļ	2, 200, 047	, 555

	Financial Systems METHODIST HOSP ATION OF REIMBURSEMENT SETTLEMENT	PITALS, INC Provider CCN: 15-0002	In Lie	u of Form CMS-2	2552-10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	From 01/01/2019		
			To 12/31/2019	Date/Time Pre 6/25/2020 8:03	pared: 3 am
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		0	0	35.00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (s	0. 000000000 ee 5, 535, 062		35. 01 35. 02
00.02	instructions)	, ,	0,000,002		
35. 03 36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.	. 03)	4, 139, 922 5, 304, 024		35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)		ugh 46) 0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.00
41. 01	1	S-DRGs 652, 682, 683, 68	4 0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0. 00 e 0		42. 00 43. 00
44. 00	instructions) Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruction		0. 00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 45 subtotal (see instructions)	41. 01)	0 48, 310, 818		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	46, 310, 616		48.00
	J. (See Trist, det. dis)		<b>'</b>	Amount	
49. 00	Total payment for inpatient operating costs (see instruction	ne)		1. 00 48, 391, 872	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a		)	3, 545, 145	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	line 49 see instructions)	•	86, 337 62, 903	52. 00 53. 00
54. 00	Special add-on payments for new technologies			02, 700	54.00
54. 01	, ,			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.00
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.		through 35)	0	56. 00 57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		till odgir oo).	93, 492	58.00
59.00	Total (sum of amounts on lines 49 through 58)	,		52, 179, 749	59. 00
60.00	Primary payer payments			3, 467	60.00
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		52, 176, 282	61.00
62. 00 63. 00	Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries			3, 850, 688 513, 874	
	Allowable bad debts (see instructions)			770, 781	
65. 00	Adjusted reimbursable bad debts (see instructions)			501, 008	•
66.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		225, 048	66.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			48, 312, 728	67. 00
68.00	Credits received from manufacturers for replaced devices for				68.00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	). (For SCH See Instruction	ns)	0	69. 00 70. 00
	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70.50
70 50	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 50 70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
	Pioneer ACO demonstration payment adjustment amount (see ins	structions)			70. 89
70. 87 70. 88 70. 89	Troneer Add demonstration payment adjustment amount (see The			0	70. 90
70. 87 70. 88 70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions)				
70. 87 70. 88 70. 89 70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)				70. 92 70. 93

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre	narod:
				10 12/31/2019	6/25/2020 8: 0	
	<u> </u>	Titl∈	XVIII	Hospi tal	PPS	
			FFY	( (yyyy) 0	Amount 1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	1.00	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
70 00	the corresponding federal year for the period ending on or af Low Volume Payment-3	ter 10/1)			0	70 00
70. 98 70. 99	HAC adjustment amount (see instructions)				0	70. 98 70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			47, 722, 670	
71. 01	Sequestration adjustment (see instructions)	/			954, 453	
71. 02	Demonstration payment adjustment amount after sequestration				0	71.02
71. 03	Sequestration adjustment-PARHM pass-throughs					71.03
72.00	Interim payments				45, 761, 620	
72. 01 73. 00	Interim payments-PARHM Tentative settlement (for contractor use only)				0	72. 01 73. 00
73. 00	Tentative settlement-PARHM (for contractor use only)				U	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0.	2, 72, and			1, 006, 597	
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)				4 0/7 000	74.01
75. 00	Protested amounts (nonallowable cost report items) in accordal CMS Pub. 15-2, chapter 1, §115.2	nce with			1, 067, 092	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			l		
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	, ,				0	92.00
93. 00 94. 00	Capital outlier reconciliation adjustment amount (see instruc The rate used to calculate the time value of money (see instru				0 0. 00	93. 00 94. 00
	Time value of money for operating expenses (see instructions)	uctions)			0.00	95.00
96.00	, , , , , , , , , , , , , , , , , , , ,	tions)			0	
				Prior to 10/1		
	LICD Danier Daymant America			1.00	2. 00	
100 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			O	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			<u> </u>	0	100.00
101.00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
102 00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
102.00	HRR Adjustment for HSP Bonus Payment					
				0. 0000	0. 0000	
103.00	HRR adjustment factor (see instructions)	`				
103.00	HRR adjustment amount for HSP bonus payment (see instructions		ustment	0	0	104. 00
103. 00 104. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adj				
103. 00 104. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration per this the first year of the current 5-year demonstration pe	ration) Adj				200. 00
103. 00 104. 00 200. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration pe Lentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ration) Adj riod under				200. 00
103. 00 104. 00 200. 00 201. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration per List this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ration) Adj riod under				200. 00 201. 00
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration States this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ration) Adj riod under				200. 00 201. 00 202. 00
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Pr	ration) Adj riod under e 49)	the 21st	0		200. 00 201. 00
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration States this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ration) Adj riod under e 49)	the 21st	0		200. 00 201. 00 202. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Pr	ration) Adj riod under e 49)	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Pr	ration) Adj riod under e 49)	the 21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (Project Project Project (Project Project Pr	ration) Adj riod under e 49)	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Pr	ration) Adj riod under e 49) first year	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration (§410A Demo	ration) Adj riod under e 49) first year ructions)	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration (§410A Demonstratio	ration) Adj riod under e 49) first year ructions)	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration (§410A Demo	ration) Adj riod under e 49) first year ructions)	the 21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00

212. 00 213. 00 218. 00

Comparision of PPS versus Cost Reimbursement

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

213.00 Low-volume adjustment (see instructions)

218.00 Net Medicare Part A IPPS and cost reimbursement)

(Line 212 minus Line 212) (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 | Peri od: | Worksheet E | From 01/01/2019 | Part A Exhi bit 4 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0002

					Ic	12/31/2019	Date/lime Pre 6/25/2020 8:0	
		W (0 E B ) A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	29, 362, 547	0	29, 362, 547		29, 362, 547	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	9, 963, 704	0		9, 963, 704	9, 963, 704	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	1, 084, 459	0	1, 084, 459		1, 084, 459	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	195, 924	0		195, 924	195, 924	2.03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	19, 735, 495	0	14, 826, 916	4, 908, 579	19, 735, 495	4.00
F 00	Indirect Medical Education Adju		0.007537	0 007527	0.007527	0.007507		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 007527	0. 007527	0.007527	0. 007527	4/4 540	5.00
6.00	IME payment adjustment (see instructions)	22. 00	161, 513	0	120, 592	40, 921	161, 513	
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	81, 054	0	60, 894	20, 160	81, 054	6. 01
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	161, 513	0	120, 592	40, 921	161, 513	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	81, 054	0	60, 894	20, 160	81, 054	9. 01
	Di sproporti onate Share Adjustm	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 2277	0. 2277	0. 2277	0. 2277		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	2, 238, 647	0	1, 671, 463	567, 184	2, 238, 647	11.00
11. 01	Uncompensated care payments	36. 00	5, 304, 024	0	4, 139, 922	1, 164, 102	5, 304, 024	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESI 46.00	ки beneтiciary n	di scharges 0	O	O	0	12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	48, 310, 818	0	36, 378, 983	11, 931, 835	48, 310, 818	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	0	0	40, 310, 010	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	48, 391, 872	0	36, 439, 877	11, 951, 995	48, 391, 872	15. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C	CN: 15-0002	Period: From 01/01/2019 To 12/31/2019		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	3, 545, 145	0			3, 545, 145	16.00
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00				0	39, 107, 50	12, 829, 512	51, 937, 017	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2.00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		3, 183, 660 0	0	2, 389, 00	06 794, 654 0 0	3, 183, 660 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	74, 956 0	0 0	63, 61	2 0 11, 344 0	74, 956 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0041	0. 0041	0. 004	0. 0041		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	13, 053	0	9, 79	3, 258	13, 053	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0859	0. 0859	0. 085	0. 0859		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	273, 476	0	205, 21	5 68, 261	273, 476	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 545, 145	0	2, 667, 62	8 877, 517	3, 545, 145	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)	2.22	0.00	4.00	5 00	
27. 00	Low volume adjustment factor	0	1. 00	2. 00	3. 00 0. 00000	4. 00 0. 000000	5. 00	27. 00
28. 00	Low volume adjustment ractor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0.000000	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

				T	12/31/2019	Date/Time Pre	pared:
			T: +1 o	VV/IIII	Hooni tal	6/25/2020 8: 0	3 am
		Wkst. E, Pt.	Amt. from	XVIII Period to	Hospital Period on	PPS Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
1.00	INDO	0	1.00	2. 00	3. 00	4. 00	1 00
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	29, 362, 547	29, 362, 547		29, 362, 547	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	9, 963, 704		9, 963, 704	9, 963, 704	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	1, 084, 459	1, 084, 459		1, 084, 459	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)		195, 924		195, 924	195, 924	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	4 000 570	0	3.00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	19, 735, 495	14, 826, 916	4, 908, 579	19, 735, 495	4. 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 007527	0. 007527	0. 007527		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	161, 513	120, 592	40, 921	161, 513	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	81, 054	60, 894	20, 160	81, 054	6. 01
	instructions) Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	he MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000		_	
8. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions)	27. 00 28. 00	0. 000000 0	0. 000000	0. 000000	0	8. 00
	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed	27. 00	0. 000000	0. 000000		0	
8. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions)	27. 00 28. 00	0. 000000 0	0. 000000			8. 00
8. 00 8. 01	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	27. 00 28. 00 28. 01	0. 000000 0 0	0. 000000 0 0	0	0	8. 00 8. 01
8. 00 8. 01 9. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	27. 00 28. 00 28. 01 29. 00	0. 000000 0 0 161, 513	0. 000000 0 0 120, 592	0 0 40, 921	0 161, 513	8. 00 8. 01 9. 00
8. 00 8. 01 9. 00 9. 01	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	27. 00 28. 00 28. 01 29. 00 29. 01	0. 000000 0 0 161, 513 81, 054	0. 000000 0 0 120, 592 60, 894	0 0 40, 921 20, 160	0 161, 513	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions)	27. 00 28. 00 28. 01 29. 00	0. 000000 0 0 161, 513	0. 000000 0 0 120, 592	0 0 40, 921	0 161, 513	8. 00 8. 01 9. 00
8. 00 8. 01 9. 00 9. 01	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage	27. 00 28. 00 28. 01 29. 00 29. 01	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647	0. 000000 0 0 120, 592 60, 894	0 0 40, 921 20, 160 0. 2277	0 161, 513	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024	0. 000000 0 0 120, 592 60, 894	0, 2277 567, 184	0 161, 513 81, 054 2, 238, 647	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00 RD beneficiary	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463	0, 2277 567, 184	0 161, 513 81, 054 2, 238, 647 5, 304, 024	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463	0, 2277 567, 184	0 161, 513 81, 054 2, 238, 647	8. 00 8. 01 9. 00 9. 01 10. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions)	27. 00  28. 00  28. 01  29. 00  29. 01  33. 00  34. 00  36. 00  RD beneficiary  46. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102	0 161, 513 81, 054 2, 238, 647 5, 304, 024	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00  RD beneficiary 46. 00 47. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102	0 161, 513 81, 054 2, 238, 647 5, 304, 024	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	27. 00  28. 00  28. 01  29. 00  29. 01  33. 00  34. 00  36. 00  RD beneficiary  46. 00  47. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs	27. 00  28. 00  28. 01  29. 00  29. 01  33. 00  34. 00  36. 00  RD beneficiary  46. 00  47. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	IME payment adjustment factor (see instructions)  IME adjustment (see instructions)  IME payment adjustment add on for managed care (see instructions)  Total IME payment (sum of lines 6 and 8)  Total IME payment for managed care (sum of lines 6.01 and 8.01)  Disproportionate Share Adjustment  Allowable disproportionate share percentage (see instructions)  Disproportionate share adjustment (see instructions)  Uncompensated care payments  Additional payment for high percentage of ESI Total ESRD additional payment (see instructions)  Subtotal (see instructions)  Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)  Total payment for inpatient operating costs (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00  RD beneficiary 46. 00 47. 00 48. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges 0 48, 310, 818 0	0. 000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00  RD beneficiary 46. 00 47. 00 48. 00  49. 00 50. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges 0 48, 310, 818 0	0. 0000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00 47. 00 48. 00  49. 00 50. 00 54. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges 0 48, 310, 818 0 48, 391, 872 3, 545, 145	0. 0000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0 36, 439, 877 2, 667, 628	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0 48, 391, 872 3, 545, 145	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00  RD beneficiary 46. 00 47. 00 48. 00  49. 00 50. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges 0 48, 310, 818 0 48, 391, 872 3, 545, 145	0. 0000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0 36, 439, 877 2, 667, 628	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0 48, 391, 872 3, 545, 145	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01	IME payment adjustment factor (see instructions)  IME adjustment (see instructions)  IME payment adjustment add on for managed care (see instructions)  Total IME payment (sum of lines 6 and 8)  Total IME payment for managed care (sum of lines 6.01 and 8.01)  Disproportionate Share Adjustment  Allowable disproportionate share percentage (see instructions)  Disproportionate share adjustment (see instructions)  Uncompensated care payments  Additional payment for high percentage of ESI  Total ESRD additional payment (see instructions)  Subtotal (see instructions)  Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)  Total payment for inpatient operating costs (see instructions)  Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  Special add-on payments for new technologies Net organ acquisition cost  Credits received from manufacturers for	27. 00 28. 00 28. 01 29. 00 29. 01  33. 00 34. 00 36. 00 47. 00 48. 00  49. 00 50. 00 54. 00	0. 000000 0 161, 513 81, 054 0. 2277 2, 238, 647 5, 304, 024 di scharges 0 48, 310, 818 0 48, 391, 872 3, 545, 145	0. 0000000 0 120, 592 60, 894 0. 2277 1, 671, 463 4, 139, 922 0 36, 378, 983 0 36, 439, 877 2, 667, 628	0 40, 921 20, 160 0. 2277 567, 184 1, 164, 102 0 11, 931, 835 0	0 161, 513 81, 054 2, 238, 647 5, 304, 024 0 48, 310, 818 0 48, 391, 872 3, 545, 145	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 17. 02

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CC		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	3, 183, 660	2, 389, 00	6 794, 654	3, 183, 660	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	74, 956	63, 61	2 11, 344	74, 956	21.00
21.01   Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00   Indirect medical education percentage (see instructions)	5. 00	0. 0041	0. 004	0. 0041		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	13, 053	9, 79	5 3, 258	13, 053	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0859	0. 085	9 0. 0859		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	273, 476	205, 21	68, 261	273, 476	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	3, 545, 145	2, 667, 62	877, 517	3, 545, 145	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	-27, 800	12, 66	-40, 468	-27, 800	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	-	0	0	30. 01
21 00 HDD adjustment (see instructions)	70.04	E42 2E0	125 75	124 502	E42 2E0	21 00

70. 91

0

70. 99

-562, 258

1.00

-425, 756

0

2.00

-136, 502

3. 00

-562, 258

(Amt. to Wkst. E, Pt. A) 4.00 31.00

31.01

32.00

100.00

0

31.00 HRR adjustment (see instructions)
31.01 HRR adjustment for HSP bonus payment (see instructions)

32.00 HAC Reduction Program adjustment (see

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

instructions)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/25/2020 8:03 am

		Title XVIII	Hospi tal	6/25/2020 8: 0 PPS	3 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			7, 971	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions	)		22, 524, 426	2.00
3.00	OPPS payments			20, 671, 817	3.00
4.00	Outlier payment (see instructions)			250, 652	1
4. 01	Outlier reconciliation amount (see instructions)	-)		0	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	S)		0.000	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	ł
8. 00	Transitional corridor payment (see instructions)			0.00	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol. 13, line 200		101, 676	1
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 971	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			4/ 045	1 40 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	0)		46, 815 0	ı
14. 00	Total reasonable charges (sum of lines 12 and 13)	9)		46, 815	ı
14.00	Customary charges			40,013	14.00
15. 00	Aggregate amount actually collected from patients liable for payme	nt for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for pay			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		44) (	46, 815	
19. 00	Excess of customary charges over reasonable cost (complete only if instructions)	Tine 18 exceeds II	ne II) (see	38, 844	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	TITIC TT CACCCUS TT	110 10) (300		20.00
21.00	Lesser of cost or charges (see instructions)			7, 971	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			21, 024, 145	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAU soo inst	cuctions)	0 3, 586, 091	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			17, 446, 025	1
27.00	instructions)	the sum of fiftes 22	- una 20] (500	17, 110, 020	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 5	0)		30, 950	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			17, 476, 975	
31. 00	Primary payer payments			10, 534	
32. 00	Subtotal (line 30 minus line 31)			17, 466, 441	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			900, 486	1
	Adjusted reimbursable bad debts (see instructions)			585, 316	
	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		654, 403	1
37.00	Subtotal (see instructions)	,		18, 051, 757	1
38.00	MSP-LCC reconciliation amount from PS&R			618	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replaced d	evices (see instruc	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0 18, 051, 139	39. 99 40. 00
40. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			361, 023	
40. 01	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs				40. 02
	Interim payments			17, 905, 888	ı
41.01	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	
42. 01	,				42.01
43.00	Balance due provider/program (see instructions)			-215, 772	1
43. 01	Balance due provider/program-PARHM (see instructions)	ii +h CMC Dub 1F 0	chanter 1	_	43.01
44. 00	Protested amounts (nonallowable cost report items) in accordance w §115.2	i tii UMS PUD. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002		Worksheet E
	Component CCN: 15-T002	From 01/01/2019 To 12/31/2019	
	compensate com to recu	12/01/201/	6/25/2020 8: 03 am
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		1, 868	2.00
3. 00	OPPS payments			568	1
4.00	Outlier payment (see instructions)			0	
4. 01 5. 00	Outlier reconciliation amount (see instructions)	tions)		0. 000	
6. 00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	ti ons)		0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		2	9.00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			Ö	1
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p	3	~	0	
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e	•)		0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
19. 00	Excess of customary charges over reasonable cost (complete only	v if line 18 exceeds li	ne 11) (see	0	1
.,	instructions)	,	, (555	ا	17.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions)	ueti ens)		0	22.00
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		570	1
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			370	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	)		0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr	ructions)	114	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	2 and 23] (see	456	27. 00
00.00	instructions)	50)		,	00.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
	Subtotal (sum of lines 27 through 29)			456	1
	Primary payer payments			430	1
	Subtotal (line 30 minus line 31)			456	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			0	1
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		0 456	
	MSP-LCC reconciliation amount from PS&R			430	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ö	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	)		1	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			456	
	Sequestration adjustment (see instructions)			9	
40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			445	40. 03 41. 00
	Interim payments-PARHM			1 445	41.01
	Tentative settlement (for contractors use only)			0	1
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			2	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	1
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems METHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/25/2020 8:03 am Provider CCN: 15-0002

					6/25/2020 8: 0	3 am
			XVIII	Hospi tal	PPS	
		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		44, 836, 157		16, 981, 654	1. 00
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
	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	12/31/2019	925, 463	12/31/2019	924, 234	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		925, 463		924, 234	3. 99
	3. 50-3. 98)		45 7/4 /00		47 005 000	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		45, 761, 620		17, 905, 888	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
F 00	List separately each tentative settlement payment after	T				5. 00
5. 00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		0			5. 02
5. 03			0			5. 03
0.00	Provider to Program	l				0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		o o		ا	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 006, 597		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		215, 772	6. 02
7. 00	Total Medicare program liability (see instructions)		46, 768, 217		17, 690, 116	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor				Ι Π	8. 00

Health Financial Systems	METHODIST HOSE	PITALS, INC	In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SEI	RVI CES RENDERED	Provider CCN: 15-0002	Peri od: From 01/01/2019	Worksheet E-1 Part I	
		Component CCN: 15-S002	To 12/31/2019	Date/Time Pre 6/25/2020 8:0	
		Title XVIII	Subprovi der -	PPS	
			I PF		
		Inpatient Part A	Par	t B	

		litle	e XVIII	Subprovi der - I PF	PPS	
		I npati en	it Part A		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		1, 042, 096		0	1.00
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
	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		0		0	3. 01
3. 02			0		0	
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 77	3. 50-3. 98)				Ĭ	3. //
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 042, 096		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T	T	Г	
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) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5. 02	TERMINAL TO TROVIDER		l		Ö	
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		4, 010		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 0		Ö	6.02
7. 00	Total Medicare program liability (see instructions)		1, 046, 106		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	
8. 00	Name of Contractor				l	8.00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	SERVI CES RENDERED	Provider CCN: 15-0002	Peri od: From 01/01/2019	Worksheet E-1 Part I
		Component CCN: 15-T002	To 12/31/2019	Date/Time Prepared: 6/25/2020 8:03 am
		Title XVIII	Subprovi der -	PPS

		Title	· XVIII	Subprovi der - I RF	PPS	
		I npati en	it Part A		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		6, 323, 986	)	445	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER		C	)	0	3. 01
3.02			(	)	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 3. 53					0	3. 52 3. 53
3. 53 3. 54					0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
3. 99	3. 50-3. 98)			,		3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		6, 323, 986		445	4. 00
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
E 04	Program to Provider					E 04
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02 5. 03					0	5. 02 5. 03
5.05	Provider to Program				U	5.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTITY E TO TROOK IIII				0	5. 51
5. 52					Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C	)	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		28, 927	·	2	6. 01
6. 02	SETTLEMENT TO PROGRAM		, c		0	6.02
7.00	Total Medicare program liability (see instructions)		6, 352, 913		447	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor			1		8. 00

Heal th	Financial Systems ME	THODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-0002	Peri od: From 01/01/2019	Worksheet E-1 Part II	
					Date/Time Pre 6/25/2020 8:0	
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD CO					4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AN					
1. 00	Total hospital discharges as defined in AARA §4			e 14		1.00
2.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6					3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum		-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col.					5. 00
6.00	Total hospital charity care charges from Wkst.	S-10, col. 3 li	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the	purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8.00	Calculation of the HIT incentive payment (see i	nstructions)				8. 00
9.00	Sequestration adjustment amount (see instruction	ns)				9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAP	Н				
30.00	Initial/interim HIT payment adjustment (see ins	tructions)				30.00
31.00	Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10) minus	line 30 and li	ine 31) (see instruction	ns)		32.00
				•		•

Health Financial Systems	METHODIST HOSPITALS. INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2019	Worksheet E-3	
	Component CCN: 15-S002			
	Title XVIII	Subprovi der - I PF	PPS	
	·			
			1. 00	
PART II - MEDICARE PART A SERVICES - IPF PPS				

		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 164, 348	1.00
2.00	Net IPF PPS Outlier Payments	3, 971	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5. 00	New Teaching program adjustment. (see instructions)	0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	6. 00
7 00	teaching program" (see instuctions)	0.00	7 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new transhing program" (assignment)	0. 00	7. 00
8. 00	teaching program" (see instuctions)	0.00	8. 00
9. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)  Average Daily Census (see instructions)	8. 263014	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00		0.000000	11.00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 168, 319	
13. 00		0	13.00
	Organ acquisition (DO NOT USE THIS LINE)	ĭ	14. 00
15. 00		0	
	Subtotal (see instructions)	1, 168, 319	
	Primary payer payments	0	
	Subtotal (line 16 less line 17).	1, 168, 319	18.00
	Deducti bl es	54, 488	
20.00	Subtotal (line 18 minus line 19)	1, 113, 831	20.00
21.00	Coi nsurance	50, 468	21.00
22.00	Subtotal (line 20 minus line 21)	1, 063, 363	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5, 487	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	3, 567	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 467	25.00
	Subtotal (sum of lines 22 and 24)	1, 066, 930	
	Direct graduate medical education payments (see instructions)	0	
28. 00	3	525	
	Outlier payments reconciliation	0	
30.00		0	
30. 50		0	
	Demonstration payment adjustment amount before sequestration	0	
	Total amount payable to the provider (see instructions)	1, 067, 455	
31. 01		21, 349	
	Demonstration payment adjustment amount after sequestration	0	-
32.00		1, 042, 096 0	32. 00 33. 00
34. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	4, 010	
35. 00		4,010	35. 00
33.00	§115. 2	١	33.00
	TO BE COMPLETED BY CONTRACTOR		
50. 00		3, 971	50. 00
	Outlier reconciliation adjustment amount (see instructions)	3, 7/1	
	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)		53.00
	1	۰۱	

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3	
		From 01/01/2019		
	Component CCN: 15-T002	To 12/31/2019	Date/Time Pre	pared:
			6/25/2020 8:0	<u>3 am </u>
	Title XVIII	Subprovi der -	PPS	
		I RF		
			1. 00	
PART III - MEDICARE PART A SERVICES - IRF PPS	S			

DART 111 - MEDICARE PART A SERVICES - IRF PPS		IRF		
PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
Net Federal PSP Symment (see instructions)		DART LLL MEDICARE DART A CEDVICES LDE DOS	1.00	
	1 00		E 740 202	1 00
Inpati ent Rehabilitation LIP Payments (see instructions)   337,833 3, 0.0				
0.00   0.01   Ire Payments   0.00   5.00   0.00   5.01   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00		, , , ,		
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to to November 15, 2004 (see instructions)				
to November 15, 2004 (see instructions) 5.01 cap increases for the unwel pitted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR 9412.424(d) (1)(III)(F)(I) (I) (0 or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unwelghated IEE count of IsR excluding FTES in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unwelghated IEE count of IsR excluding FTES in the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.01 Oxidate PSP Payment (see instructions) 9.02 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.03 Vergage Dail y Cersus (see instructions) 9.04 Vergage Dail y Cersus (see instructions) 9.05 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.06 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.07 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.08 Intern and resident feature (see instructions) 9.09 Intern and resident feature (see instructions) 9.00 Intern and resident feature (see instructions) 9.00 Intern and resident feature (see instructions) 9.01 Intern and resident feature (see instructions) 9.02 Intern and resident feature (see instructions) 9.03 Intern and resident feature (see instructions) 9.04 Intern and resident feature (see instructions) 9.05 Intern and resident feature (see instructions) 9.06 Intern and resident feature (see instructions) 9.07 Intern and resident feature (see instructions) 9.08 Intern and resident feature (see instructions) 9.09 Intern and All Intern and PPS payment (see instructions) 9.00 Intern and PPS pay				
5.01   Cap increases for the unweighted interm and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42   CFR \$412.424(d)(1)(III)(F)(1) or (2) (see instructions)   0.00	5.00		0.00	3.00
CFR \$412, 424(d)()(iii)(F)(1) or (2) (see instructions)	5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
New Teaching program adjustment. (see instructions)   0.00   0.				
2.00   Current year's unwelghted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00   8.00	6.00		0.00	6.00
teaching/program" (see instructions)	7.00		0.00	7. 00
teaching program" (see instructions)   0,00   9.00				
9,00   Interm and resident count for IRF PPS medical education adjustment (see instructions)   0,00   9,00   10.00   Teaching Adjustment Factor (see instructions)   0,000000   11.00   10.0	8. 00		0. 00	8. 00
10. 00   Average Daily Census (see instructions)   21.331507   10. 00	0.00		0.00	0.00
11. 00   Teaching Adjustment Factor (see instructions)   0.000000   11. 00   12. 0				
12.00   Teaching Adjustment (see instructions)   12.00   13.				
13.00   Total PPS Payment (see instructions)   13.00   14.00   14.00   15.00   16.00		, ,	1	
14.00				
15.00				
16. 00   Cost of physicians' services in a teaching hospital (see instructions)   0   16. 00   17. 00   18. 0			ال	
17.00   Subtotal (see instructions)   17.00   18.00   Primary payer payments   0   18.00   18.00   Primary payer payments   0   18.00   18.00   Primary payer payments   0   18.00				
18.00				
19.00   Subtotal (line 17 less line 18).   6,519,938   19.00   20.00   Deductibles   24,528   20.00   20.00   Deductibles   22,000   22.00   Coinsurance   22.90   Coinsurance   22.90   Subtotal (line 21 minus line 22)   22.00   Subtotal (line 21 minus line 22)   22.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   25,965   24.00   25.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   16,877   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   17,026   26.00   27.00   Subtotal (sum of lines 23 and 25)   6,482,387   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 28.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.0				
20. 00   Deductibles   24. 528   20. 00			1	
21.00   Subtotal (line 19 minus line 20)   6, 495, 410   21.00   22.00   Coinsurance   29,900   22.00   23.00   Subtotal (line 21 minus line 22)   6,465,510   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   25,965   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   16,877   25.00   27.00   Subtotal (sum of lines 23 and 25)   6,482,387   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   28.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   21.00   28.00   00   00   00   00   00   00   00				
22.00				
23.00   Subtotal (line 21 minus line 22)   6,465,510   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   25,965   24.00   25.00   Allowable bad debts (see instructions)   16,877   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   17,026   26.00   27.00   Subtotal (sum of lines 23 and 25)   6,482,387   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   177   29.00   29.00   Other pass through costs (see instructions)   0   31.00   31.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   31.50   31.99   Demonstration payment adjustment amount before sequestration   0   31.99   32.01   Sequestration adjustment (see instructions)   6,482,564   32.00   32.01   Sequestration adjustment (see instructions)   6,482,564   32.00   33.00   Interim payment adjustment amount after sequestration   0   32.02   33.00   Interim payment adjustment amount after sequestration   0   34.00   Tentative settlement (for contractor use only)   0   34.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   36.00   37.50   38.00   Other pass through the payment amount (see instructions)   0   37.50   38.00   Other payment amount from Wkst. E-3, Pt. III, line 4   387,853   50.00   37.00   Other payment agustment amount (see instructions)   0   37.00   3				
24. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       25, 965       24. 00         25. 00       Adjusted reimbursable bad debts (see instructions)       16, 877       25. 00         26. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       17, 026       26. 00         27. 00       Subtotal (sum of lines 23 and 25)       6, 482, 387       27. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28. 00         29. 00       Other pass through costs (see instructions)       177       29. 00         30. 00       Outlier payments reconciliation       0       30. 00         31. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31. 00         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31. 50         31. 90       Demonstration payment adjustment amount before sequestration       0       31. 99         32. 01       Sequestration adjustment (see instructions)       129, 651       32. 01         32. 02       Demonstration payment adjustment amount after sequestration       0       32. 02         33. 00       Interim payments       6, 482, 564       32. 00         32. 01       Interim payments				
25. 00 Adjusted reimbursable bad debts (see instructions)  26. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  27. 00 Subtotal (sum of lines 23 and 25)  28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29. 00 Other pass through costs (see instructions)  30. 00 Utilier payments reconciliation  31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  31. 50 Pioneer ACO demonstration payment adjustment (see instructions)  31. 90 Demonstration payment adjustment amount before sequestration  32. 00 Total amount payable to the provider (see instructions)  32. 01 Sequestration adjustment (see instructions)  32. 02 Sequestration adjustment (see instructions)  33. 00 Interim payments  40. 32. 02 Demonstration payment adjustment amount after sequestration  50. 00 Tentative settlement (for contractor use only)  36. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  70. 00 Total amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  70 BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment (see instructions)  The rate used to calculate the Time Value of Money  50. 00 The rate used to calculate the Time Value of Money  51. 00  The rate used to calculate the Time Value of Money				
26. 00 Alíowable bad debts for dual eligible beneficiaries (see instructions)  27. 00 Subtotal (sum of lines 23 and 25)  28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29. 00 Other pass through costs (see instructions)  30. 00 Outlier payments reconciliation  31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  31. 50 Pioneer ACO demonstration payment adjustment (see instructions)  31. 90 Demonstration payment adjustment amount before sequestration  32. 00 Total amount payable to the provider (see instructions)  32. 01 Sequestration adjustment (see instructions)  32. 02 Demonstration payment adjustment amount after sequestration  32. 02 Demonstration payment adjustment amount after sequestration  33. 00 Interim payments  34. 00 Tentative settlement (for contractor use only)  35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  36. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4  51. 00 Outlier reconciliation adjustment amount (see instructions)  52. 00 The rate used to calculate the Time Value of Money  53. 00 The rate used to calculate the Time Value of Money  54. 00 Subtotal (sum of lines 23 and 25)  55. 00 Time rate used to calculate the Time Value of Money  55. 00 Time rate used to calculate the Time Value of Money  56. 00 Original outlier amount from Value of Money  57. 00 Original outlier amount from Value of Money  58. 00 Original outlier amount from Value of Money  59. 00 Original outlier amount from Value of Money  59. 00 Original outlier amount from Value of Money				
27. 00 Subtotal (sum of lines 23 and 25)  28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29. 00 Other pass through costs (see instructions)  30. 00 Outlier payments reconciliation  31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  31. 50 Pioneer ACO demonstration payment adjustment (see instructions)  31. 99 Demonstration payment adjustment amount before sequestration  32. 00 Sequestration adjustment (see instructions)  32. 01 Sequestration adjustment (see instructions)  32. 02 Demonstration payment adjustment amount after sequestration  32. 02 Demonstration payment adjustment amount after sequestration  32. 02 Demonstration payment adjustment amount after sequestration  32. 01 Interim payments  33. 00 Interim payments  46, 323, 986 33. 00  34. 00 Sequestration adjustment (for contractor use only)  35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  36. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  387, 853 50. 00  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4  387, 853 50. 00  51. 00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  30 Contractor  31 Contractor  32 Contractor  32 Contractor  33 Contractor  34 Contractor  34 Contractor  35 Contractor  36 Contractor  37 Contractor  38 Contractor		, ,		
28.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28.00         29.00       Other pass through costs (see instructions)       177       29.00         30.00       Outlier payments reconciliation       0       30.00         31.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31.50         31.99       Demonstration payment adjustment amount before sequestration       0       31.99         32.01       Sequestration adjustment (see instructions)       6, 482,564       32.00         32.01       Demonstration payment adjustment amount after sequestration       129,651       32.01         32.02       Interim payments       6, 323,986       33.00         34.00       Interim payments       6, 323,986       33.00         35.00       Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)       28,927       35.00         36.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       36.00         50.00       Original outlier amount from Wkst. E-3, Pt. III, line 4       387,853       50.00         50.00       The rate used to calculate the Time Value of Money       0.00<		· · · · · · · · · · · · · · · · · · ·		
29.00       Other pass through costs (see instructions)       177       29.00         30.00       Outlier payments reconciliation       0       30.00         31.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31.50         31.90       Demonstration payment adjustment amount before sequestration       0       31.99         32.01       Sequestration adjustment (see instructions)       6, 482, 564       32.00         32.01       Sequestration payment adjustment amount after sequestration       0       32.01         32.02       Demonstration payment adjustment amount after sequestration       0       32.02         33.00       Interim payments       6, 323, 986       33.00         34.00       Tentative settlement (for contractor use only)       0       34.00         35.00       Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)       28, 927       35.00         36.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       36.00         51.5.0       Outlier reconciliation adjustment amount (see instructions)       0       51.00         50.00       The rate used to calculate the Time Value of M				
30.00 Outlier payments reconciliation 0 30.00 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 31.99 Demonstration payment adjustment amount before sequestration 0 31.50 32.00 Total amount payable to the provider (see instructions) 6, 482, 564 32.00 32.01 Sequestration adjustment (see instructions) 129, 651 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 32.02 33.00 Interim payments 6, 323, 986 33.00 34.00 Tentative settlement (for contractor use only) 6, 329, 986 33.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 28, 927 35.00 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 37.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 387, 853 50.00 387, 853 50.00 39.00 The rate used to calculate the Time Value of Money 0.00 52.00				
31.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   31.00   31.50   21.00   31.50   21.00   21.50		, , , , , , , , , , , , , , , , , , , ,		
31.50 Pioneer ACO demonstration payment adjustment (see instructions)  31.99 Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment (see instructions)  129,651  32.01  33.00  Interim payments  Constrative settlement (for contractor use only)  Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Outlier reconciliation adjustment amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)  Discontinuations  31.50  31.50  31.50  31.50  31.99  32.00  32.01  32.01  32.01  32.01  32.01  32.01  32.01  32.01  32.01  32.01  33.00  34.00  35.00  36.00  37.00  38.00  39.00  39.00  30.00				
31.99   Demonstration payment adjustment amount before sequestration   0   31.99   32.00   Total amount payable to the provider (see instructions)   6,482,564   32.00   32.01   32.02   32.02   32.02   32.00   32.02   33.00   Interim payment adjustment amount after sequestration   0   32.02   33.00   Interim payments   0,323,986   33.00   34.00   Tentative settlement (for contractor use only)   0   34.00   35.00   Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)   28,927   35.00   36.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   36.00   36.00   37.02   38.00				
Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  1129, 651  32.01  32.02  33.00  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00  Silb. 2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  O. 00 52.00				
32.01   Sequestration adjustment (see instructions)   129,651   32.01   32.02   33.00   Interim payment adjustment amount after sequestration   0   32.02   33.00   Interim payments   6,323,986   33.00   34.00   35.00   Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)   28,927   35.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   36.00   Silon   Si				
32.02 Demonstration payment adjustment amount after sequestration  32.02 33.00 Interim payments  Tentative settlement (for contractor use only)  35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  0 Utlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  32.02  33.00  34.00  34.00  35.00  36.00  37.00  38.00  50.00  50.00  50.00  50.00	32.00	Total amount payable to the provider (see instructions)	6, 482, 564	32.00
33.00 Interim payments  1. Interim payments  2. Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28, 927 35.00 Since the settlement (provider/program (lines 32.01, 32.02, 33, and 34)  28, 927 36.00 Since the settlement (provider		Sequestration adjustment (see instructions)	129, 651	
34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Silbs COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 0 Outlier reconciliation adjustment amount (see instructions) 10 Outlier reconciliation adjustment amount (see instructions) 11 Outlier reconciliation adjustment amount (see instructions) 12 Outlier reconciliation adjustment amount (see instructions) 13 Outlier reconciliation adjustment amount (see instructions) 13 Outlier reconciliation adjustment amount (see instructions) 14 Outlier reconciliation adjustment amount (see instructions) 15 Outlier reconciliation adjustment amount (see instructions) 16 Outlier reconciliation adjustment amount (see instructions) 17 Outlier reconciliation adjustment amount (see instructions) 18 Outlier reconciliation adjustment amount (see instructions) 19 Outlier reconciliation adjustment amount (see instructions) 10 Outlier reconciliation adjustment amount (see instructions) 11 Outlier reconciliation adjustment amount (see instructions) 12 Outlier reconciliation adjustment amount (see instructions) 13 Outlier reconciliation adjustment amount (see instructions)	32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  28,927 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub.	33.00	Interim payments	6, 323, 986	33.00
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 \$\frac{\sqrt{115.2}}{\sqrt{10 BE COMPLETED BY CONTRACTOR}}\$  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 387,853 50.00 0utlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	34.00	Tentative settlement (for contractor use only)	0	34.00
\$115.2 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  50.00 See The Value of Money	35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	28, 927	35.00
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  50.00 See The Proceedings of the Contract of the Co	36. 00		0	36. 00
51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  0.00 51.00				
51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  0.00 51.00	50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	387, 853	50.00
52.00 The rate used to calculate the Time Value of Money 0.00 52.00			0	51.00
53.00 Time Value of Money (see instructions) 0 53.00		, , , , , , , , , , , , , , , , , , , ,	0.00	52.00
	53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/25/2020 8:03 am	
	T: +1 - VIV	11! +-1	C+	

			0 12/31/2019	6/25/2020 8: 0	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		5, 962, 416		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5, 962, 416	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5, 962, 416	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				]
8.00	Routi ne servi ce charges		4, 320, 813		8.00
9.00	Ancillary service charges		16, 791, 028	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		21, 111, 841	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14. 00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)		21, 111, 841	0	
17. 00		ly if line 16 exceeds	15, 149, 425	0	17.00
10.00	line 4) (see instructions)	l ! &   ! == 4 =====	0		10.00
18. 00	, , , , , , , , , , , , , , , , , , ,	Ty IT Time 4 exceeds Time	U	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
	, ,	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		5, 962, 416	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			U	21.00
22 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		o o	١	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		o	0	1
	Subtotal (sum of lines 22 through 26)		o	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		5, 962, 416	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	5, 962, 416	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	5, 962, 416	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00			5, 962, 416	0	
39.00	,		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		5, 962, 416	0	
41.00	Interim payments		7, 119, 262	0	
42.00	Balance due provider/program (line 40 minus line 41)		-1, 156, 846	0	
43.00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		I

METHODIST HOSPITALS, INC	ALS, INC In Lieu		
Provi der CCN: 15-0002		Worksheet E-3	
Component CCN: 15-S002		Date/Time Pre	
Title XIX	Subprovi der -	Cost	
	I PF		
	Provi der CCN: 15-0002 Component CCN: 15-S002	Provider CCN: 15-0002 Period: From 01/01/2019 To 12/31/2019  Title XIX Subprovider - IPF	Provider CCN: 15-0002

		I PF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1. 00	Inpatient hospital/SNF/NF services	0		1. 00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6. 00	Outpatient primary payer payments		0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8. 00	Routine service charges	0		8.00
9. 00	Ancillary service charges	0	0	9. 00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
40.00	CUSTOMARY CHARGES			40.00
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
14 00	basis		0	14.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0. 000000	0. 000000	15. 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		16. 00
17. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only if line 16 exceeds		0	17. 00
17.00	line 4) (see instructions)	U U	U	17.00
10 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	U U	U	10.00
19. 00	Interns and Residents (see instructions)	0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21. 00			0	21. 00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide		0	21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments	o	0	23. 00
24. 00	1	0	ŭ	24. 00
25. 00	Capital exception payments (see instructions)	o		25. 00
26. 00	Routine and Ancillary service other pass through costs	o	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	o	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	' '		
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32. 00	Deducti bl es	o	0	32.00
33. 00	Coinsurance	o	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2			

Health Financial Systems	th Financial Systems METHODIST HOSPITALS, INC		u of Form CMS-2552-1	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2019	Worksheet E-3	
	Component CCN: 15-T002			
	Title XIX	Subprovi der -	Cost	
		I RF		
		1	O + + ! +	

		IRF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	193, 930		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	193, 930	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	193, 930	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e Charges			
8.00	Routine service charges	123, 560		8. 00
9.00	Ancillary service charges	290, 695	0	9. 00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	414, 255	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
	basis			
14.00	Amounts that would have been realized from patients liable for payment for services of	on 0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)	414, 255	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	220, 325	0	17.00
	line 4) (see instructions)			
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds lin	ne 0	0	18.00
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	0	0	19.00
20.00		0	0	20.00
21. 00		193, 930	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provi			
		0	0	22.00
23.00		0	0	23.00
24.00		0		24.00
25.00		0		25.00
26. 00	Routine and Ancillary service other pass through costs	0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28. 00		0	0	28.00
29. 00		193, 930	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	· · · · · · · · · · · · · · · · · · ·	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	193, 930	0	31.00
32.00	Deducti bl es	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	193, 930	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	193, 930	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	193, 930	0	40.00
41.00		138, 720	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	55, 210	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2			

Title XVIII   Hospital   Potential Property   Pot		GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der C		Peri od: From 01/01/2019	Worksheet E-4	
COMPUTATION OF TOTAL DIRECT CMF AMOUNT   1.00   1	LDIOA	E EDUCATION COSTS					
Description of ToTAL DIRECT GNE ANDWT			Title	XVIII	Hospi tal	PPS	
10   Dissiphted resident FTE count for all opathic and osteopathic programs for cost reporting periods ending on on before December 31, 1996   10   20   20   20   20   20   20   20						1. 00	
Description of Defore December 31, 1996.   Univergithed FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)   0.00   2.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00							
Description   Color	. 00		programs for	r cost report	ing periods	10. 83	1.0
Discret CME cap reduction amount under ACA \$5003 in accordance with 42 CFR \$413.79 (m). (see   0.00 3. instructions for cost reporting periods straddill ing 771/2011)   OA Algorithment (plus or minus) to the FTE cap for all logathic and osteopathic programs due to a Medicare (GME affiliation agreement (42 CFR \$413.75(b) and \$413.79 (f))   OA CA Section \$5003 increase to the Direct CME FTE Cap (see instructions for cost reporting periods straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap (see instructions for cost reporting periods straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap (see instructions for cost reporting periods straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap slots (see instructions for cost reporting periods straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap slots (see instructions for cost reporting periods straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap slots (see instructions for cost reporting periods and straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap slots (see instructions for cost reporting periods and straddill gr 771/2011)   OA CA Section \$5003 increase to the Direct CME FTE Cap slots (see instructions)	. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see inst	ructions)		2.0
Instructions for cost reporting periods straddling 7/1/2011)   OA   Adjustment (plus or minus) to the FIE cap for all opathic and osteopathic programs due to a Medicare (and affiliation agreement (42 CFR \$413.75(b) and \$413.79 (f))   OA   OA   OA   OA   OA   OA   OA				R 8413 79 (m)	(See		3. C
CME affiliation agreement (42 CFR \$413.75(b) and § 413.79 (f))   ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)   ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)   FTE adjusted cap (in el plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 10.83   5.		instructions for cost reporting periods straddling 7/1/2011)		. ,	`		
10	00			programs due	to a Medicare	0. 00	4.0
10.00	01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		r cost report	ing periods	0. 00	4. (
Derivation   Periods straight   Periods straight   Periods straight   Periods straight   Periods   Periods straight   Periods   Period	02		s (see ins	tructions for	cost reporting	0.00	4. (
4.02 plus applicable subscripts   1.00   1		periods straddling 7/1/2011)	•				
100   Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)   3.00   7.	. 00		us or minus	line 4 plus	lines 4.01 and	10. 83	5.0
Inter the lesser of line 5 or line 6	. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	r the current	year from your	3. 00	6.0
New   Section   Primary Care   Other   Total   1.00   2.00   3.00   2.50   3.00   2.50   2.	00					3 00	7. (
Weighted FTE count for physicians in an all opathic and osteopathic program for the current year program for the current year.	. 00	Enter the respect of tribe of tribe of				Total	7. 0
Description	00	Waighted FTE count for physicians in an allonathic and osteon	nathi c				Ω (
multiply line 8 times the result of line 5 divided by the amount on line 6	. 00	program for the current year.		0.0	2. 50		
0.00   Weighted dental and podiatric resident FTE count for the current year   0.00   10.   10	00				2. 50	2. 50	9.
1.01   Unweighted dental and podiatric resident FTE count for the current year   0.00   2.50   11.			diff of Title				
1.00					I		10.
1.00			irrent year	0.0			10.
13.00	2. 00	Total weighted resident FTE count for the prior cost reportir	ng year (see				12.
year (see instructions)   1.00   Rolling average FTE count (sum of lines 11 through 13 divided by 3).   0.00   2.48   14.   14.   15.   15.   16.   16.   16.   17.   17.   17.   17.   17.   18.   17.   18.	3. 00		eporti na	0.0	2.44		13. (
15.00   Adjustment for residents in initial years of new programs   0.00   0.00   0.00   0.50   0.		year (see instructions)					
15.01   Unweighted adjustment for residents in initial years of new programs   0.00			d by 3).				
Unweighted adjustment for residents displaced by program or hospital   0.00   0.00   16.	5. 01		orograms				15.
Closure	5. 00						16.
17.   18.   17.   18.   17.   18.   17.   18.	5. 01		nospi tal	0.0	0.00		16.
2.00   Approved amount for resident costs   0   216, 589   216, 589   19.	7. 00			0.0	2. 48		17.
1.00	3.00					21/ 500	18.
Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42   0.00   20.	7. 00	Approved amount for resident costs			0 210, 589	210, 589	19.
Sec. 413.79(c)(4)   Direct GME FTE unweighted resident count over cap (see instructions)   Direct GME FTE unweighted resident count (see instructions)   O. 00   21.		A LP 11 - A L L L L L L L L L L L L L L L L L L	TE				00
0.00   Direct GME FTE unweighted resident count over cap (see instructions)   0.00   21.	). 00		· IE resident	cap slots re	cerved under 42	0.00	20.
Enter the locality adjustment national average per resident amount (see instructions)   87, 334. 14   23.	. 00		ıcti ons)			0. 00	21.
COMPUTATION OF PROGRAM PATIENT LOAD   1.00   2.00   3.00   2.00   3.00   2.00   3.00		· ·	,				
Total direct GME amount (sum of lines 19 and 24)   216,589   25.   Inpatient Part A   1.00   2.00   3.00			amount (see	instructions)			
COMPUTATION OF PROGRAM PATIENT LOAD   1.00   2.00   3.00							
1.00   2.00   3.00					Managed Care	Total	
1.00   Inpatient Days (see instructions)   32,572   16,082   26.   27.   27.   28.   28.   29.					2. 00	3. 00	
Total Inpatient Days (see instructions)   85,651   27.   28.   28.   29.   2	65						
Ratio of inpatient days to total inpatient days ON Program direct GME amount ON Percent reduction for MA DGME ON Reduction for direct GME payments for Medicare Advantage ON Ratio of inpatient days ON Ratio of i							
Program direct GME amount 82,366 40,667 123,033 29. Percent reduction for MA DGME 29. Reduction for direct GME payments for Medicare Advantage 5,746 5,746 30.							28.
0.00 Reduction for direct GME payments for Medicare Advantage 5,746 5,746 30.		' '				123, 033	
	9. 01						29.
		IReduction for direct GME nayments for Medicare Advantage		1	5, 746	5, 746	30.

Hoal th	Financial Systems METHODIST HOSPI	TALS INC	In Lie	u of Form CMS-2	2552_10	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 15-0002	Peri od:	Worksheet E-4		
	L EDUCATION COSTS		From 01/01/2019 To 12/31/2019		pared:	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING S	CHOOL AND PARAMED	I CAL		
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	8, 671, 001	33.00	
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00	
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
	Reasonable cost (see instructions)			63, 119, 647		
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0		
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0		
	Primary payer payments (see instructions)			·	40.00	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		63, 116, 180	41.00	
42.00	Part B Reasonable Cost Reasonable cost (see instructions)			22, 635, 943	42.00	
42.00	Primary payer payments (see instructions)			10, 534		
44. 00	Total Part B reasonable cost (line 42 minus line 43)			22, 625, 409		
	Total reasonable cost (sum of lines 41 and 44)			85, 741, 589		
	Ratio of Part A reasonable cost to total reasonable cost (lin	ne 41 ÷ line 45)		0. 736121		
	.00 Ratio of Part B reasonable cost to total reasonable cost (line 41 + 1 line 45)					
50	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 263879	1 50	
48. 00	Total program GME payment (line 31)	<del>-</del>		117, 287	48.00	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		86, 337		
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			30, 950		

Health Financial Systems

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

Provi der CCN: 15-0002

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am

oni y)					6/25/2020 8: 0	3 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	24, 486, 119	1	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	603, 597 373, 412	1	0	0	2. 00 3. 00
4. 00	Accounts receivable	41, 345, 749		0	0	4.00
5. 00	Other recei vable	0	l o	0	Ö	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	13, 014, 549		0	0	7.00
8. 00	Prepai d expenses	5, 320, 362		0	0	8.00
9.00	Other current assets	40, 401, 550		0	0	9.00
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	125, 545, 338	0	0	0	10.00 11.00
11.00	FIXED ASSETS	125, 545, 556	0	U	0	11.00
12.00	Land	5, 373, 674	0	0	0	12.00
13.00	Land improvements	6, 844, 912	1	0	0	13.00
14.00	Accumulated depreciation	-363, 779, 919	1	0	0	14.00
15. 00	Bui I di ngs	267, 653, 434		0	0	15.00
16.00	Accumulated depreciation	0 775 0/5	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	2, 775, 265	0	0	0	17. 00 18. 00
19. 00	Fi xed equipment			0	0	19.00
20. 00	Accumulated depreciation	Ö	Ö	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	211, 854, 063	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24.00
25. 00	Minor equipment depreciable	0	0	0	0	25.00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130, 721, 429	o	0	0	30.00
	OTHER ASSETS					
31.00	Investments	110, 899, 811	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	468, 250	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	111, 368, 061		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	367, 634, 828	1	0	0	36.00
	CURRENT LIABILITIES		-1			
37.00	Accounts payable	15, 838, 503	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39. 00	Payrol I taxes payable	0	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term)	2, 674, 296	0	0	0	40.00
41.00	Deferred income Accelerated payments	0	١	U	U	41. 00 42. 00
43. 00	Due to other funds		0	0	0	43.00
44. 00	Other current liabilities	22, 947, 998	Ö	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	41, 460, 797	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	56, 205, 056		0	0	47.00
48. 00 49. 00	Unsecured Loans Other Long term LightLitter	0	0	0	0	48. 00 49. 00
50.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	24, 659, 784 80, 864, 840	1	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	122, 325, 637	1	0	0	51.00
	CAPITAL ACCOUNTS	, , , , , , , , , , , , , , , , , , , ,	,	-		
52.00	General fund balance	245, 309, 191				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			U	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
55. 55	replacement, and expansion					55.55
59. 00	Total fund balances (sum of lines 52 thru 58)	245, 309, 191	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	367, 634, 828	0	0	0	60.00
	[59]	I				l

TALS, INC In Lieu of Form CMS-2552-10
Provider CCN: 15-0002 Period: From 01/01/2019 Worksheet G-1 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					From 01/01/2019 To 12/31/2019		
		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	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)	0	244, 416, 475 892, 716 245, 309, 191		0	0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00		0 0 0 0			0 0 0 0 0	000000000000000000000000000000000000000	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	U 245, 309, 191			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 245, 309, 191			0	18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 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)	0	0		0		1.00 2.00 3.00 4.00 5.00
6. 00 7. 00 8. 00 9. 00			0 0 0 0				6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2019 | Parts | & II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems NSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0002

PART I - PATIENT REVENUES   1.00   2.00   3.00				To	12/31/2019	Date/Time Pre 6/25/2020 8:0	
PART   - PATLENT REVENUES		Cost Center Description	Lnpat	ient	Outpati ent		o diii
PART I - PATTERT REVENUES   Seneral Inpatient Routine Services   Seneral Inpatient Routine Services   1.00   Hospi tal   2.00   Subprovider - IPF   4.966, 991   4.966, 991   2.00   3							
Ceneral Inpatient Routine Services   1,00   Hospital   1,00   Ho		PART I - PATIENT REVENUES					
1.00		General Inpatient Routine Services					
3.00   SUBPROVIDER   IRF	1.00		77,	007, 284		77, 007, 284	1.00
4, 00   SUBPROVIDER	2.00	SUBPROVI DER - I PF	4,	966, 991		4, 966, 991	2.00
1.00   SUBPROVIDER	3.00	SUBPROVI DER - I RF	7,	194, 491		7, 194, 491	3.00
Sain   Success   Sain   Success   Sain   Success   Sain	4.00	SUBPROVI DER	· ·	•			4.00
0.00   Swing bed - NF   7.00   8.00	5.00	Swing bed - SNF		0		0	5.00
8.00   NURSING FACILITY   9.00   NURSING FACILITY   9.00   Total general inpatient care services (sum of lines 1-9)   11.00	6.00	Swing bed - NF		0		0	6.00
9.00   OTHER LONG TERM CARE   9.00   0.00   10	7.00	SKILLED NURSING FACILITY					7.00
Total general inpatient care services (sum of lines 1-9)   89, 168, 766   89, 168, 766   10, 00     Total general inpatient care services (sum of lines 1-9)   89, 168, 766   10, 00     Total care lines   Vecame lin	8.00	NURSING FACILITY					8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE					9.00
Intensive Care Type Inpatient Hospital Services	10.00	Total general inpatient care services (sum of lines 1-9)	89,	168, 766		89, 168, 766	10.00
11. 01   NEONATAL ICU		Intensive Care Type Inpatient Hospital Services					
12.00   CORONARY CARE UNIT   12.00   13.00   14.00   15.00   14.00   15.00   15.00   16.00   17.00	11.00	INTENSIVE CARE UNIT	22,	213, 430		22, 213, 430	11.00
13.00   BURN INTENSIVE CARE UNIT   13.00   13.00   14.00   15.00   17.00   1	11. 01	NEONATAL I CU		0		0	11.01
14. 00   SURGICAL INTENSIVE CARE UNIT   14. 00   15. 00   10   16. 00   17. 00   10   16. 00   17. 0	12.00	CORONARY CARE UNIT					12.00
15.00   OTHER SPECIAL CARE (SPECIFY)   15.00   Total intensive care type inpatient hospital services (sum of lines 10 and 16)   111, 382, 196   111, 382, 196   111, 382, 196   111, 382, 196   17.00   10.0	13.00	BURN INTENSIVE CARE UNIT					13.00
16.00   Total intensive care type inpatient hospital services (sum of lines 10 and 16)   111.15)   17.00   Total inpatient routine care services (sum of lines 10 and 16)   111.382,196   111.382,196   18.00   Ancillary services   488,318,241   531,425,683   1,019,743,924   18.00   100	14.00	SURGICAL INTENSIVE CARE UNIT					14.00
11-15    Total inpatient routine care services (sum of lines 10 and 16)   111, 382, 196   111, 382, 196   18.00   Ancillary services   488, 318, 241   19.00   Outpatient services   24, 331, 909   107, 106, 411   131, 438, 320   19.00	15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
17. 00   Total inpatient routine care services (sum of lines 10 and 16)   111, 382, 196   488, 318, 241   531, 425, 683   1,019, 743, 924   18. 00   00   00   00   00   00   00   00	16.00	Total intensive care type inpatient hospital services (sum of I	i nes 22,	213, 430		22, 213, 430	16.00
18. 00		11-15)					
19.00	17.00	Total inpatient routine care services (sum of lines 10 and 16)	111,	382, 196		111, 382, 196	17.00
20. 00   RURÂLL HEALTH CLINIC   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 0 20.00   21.00   22.00   40.00   40.00   20.00   21.00   40.00   40.00   20.00	18.00	Ancillary services	488,	318, 241	531, 425, 683	1, 019, 743, 924	18.00
21. 00   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   21. 00	19.00	Outpati ent servi ces	24,	331, 909	107, 106, 411	131, 438, 320	19.00
22. 00   HOME HEALTH AGENCY   3, 536, 512   3, 536, 512   22. 00   23. 00   23. 00   23. 00   23. 00   23. 00   23. 00   23. 00   23. 00   23. 00   24. 00   25. 00	20.00	RURAL HEALTH CLINIC		0	0	0	20.00
23. 00 24. 00 CMHC CMHC CMHC 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.)	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
24. 00	22.00	HOME HEALTH AGENCY			3, 536, 512	3, 536, 512	22.00
25. 00   AMBULATORY SURGICAL CENTER (D.P.)   25. 00   26. 00   40SPLCE   27. 00   PHYSI CIAN REV   27. 01   PRO FEES   505, 924   52, 217, 264   52, 723, 188   27. 01   28. 00   26. 00   27. 01   28. 00   26. 00   27. 00   26. 00   27. 00   26. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   28. 00   27. 01   28. 00   28. 0	23.00	AMBULANCE SERVICES					23.00
26. 00	24.00	CMHC					24.00
27. 00 PHYSICIAN REV 27. 01 PRO FEES 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 624, 536, 302	25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
27. 01 PRO FEES Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 624, 536, 302 694, 197, 442 1, 318, 733, 744 28. 00 694, 197, 442 1, 318, 733, 744 28. 00 694, 197, 442 1, 318, 733, 744 28. 00 694, 197, 442 1, 318, 733, 744 298. 00 7 Total additions (sum of lines 30-35)  DEDUCT (SPECIFY)  PRO FEES  505, 924 624, 536, 302 694, 197, 442 1, 318, 733, 744 298. 00 344, 612, 274 29. 00 344, 612, 274 29. 00 30. 00 31. 00 32. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 36. 00 36. 00 36. 00 37. 00 36. 00 37. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total additions (sum of lines 37-41) 7. 01 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 344, 612, 274 43. 00 344, 612, 274 43. 00	26.00	HOSPI CE					26.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 624, 536, 302 694, 197, 442 1, 318, 733, 744 28.00 694, 197, 442 1, 318, 733, 744 28.00 694, 197, 442 1, 318, 733, 744 28.00 694, 197, 442 1, 318, 733, 744 28.00 694, 197, 442 1, 318, 733, 744 28.00 694, 197, 442 1, 318, 733, 744 29.00 694, 197, 442 1, 318, 733, 744 197, 442	27.00	PHYSI CI AN REV		-1, 968	-88, 428	-90, 396	27.00
G-3, line 1)   PART II - OPERATING EXPENSES   Operating expenses (per Wkst. A, column 3, line 200)   344, 612, 274   29.00   30.00   31.00   31.00   32.00   33.00   34.00   33.00   34.00   35.00   36.00   0   35.00   36.00   0   35.00   36.00   0   35.00   36.00   0   36.00   0   36.00   0   37.00   0   37.00   0   37.00   0   38.00   39.00   0   39.00   0   39.00   0   39.00   0   39.00   0   40.00   41.00   42.00   7otal operating expenses (sum of lines 29 and 36 minus line 42)(transfer   344, 612, 274   43.00   344, 612, 274   43.00   30.00   30.00   344, 612, 274   43.00   30.0	27. 01	PRO FEES		505, 924	52, 217, 264	52, 723, 188	27. 01
PART II - OPERATING EXPENSES  29.00 30.00 31.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  O  36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer)  29.00 344, 612, 274 344, 612, 274 39.00 39.40 30.00 31.00 31.00 31.00 31.00 31.00 32.00 33.00 34.00 35.00 0 36.00 37.00 0 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer)  344, 612, 274  344, 612, 274	28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 624,	536, 302	694, 197, 442	1, 318, 733, 744	28.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200)  30. 00 31. 00 31. 00 32. 00 33. 00 32. 00 33. 00 34. 612, 274 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 344, 612, 274 30. 00 344, 612, 274 30. 00 344, 612, 274 30. 00							
30.00   ADD (SPECIFY)   0   30.00   31.00   32.00   33							
31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer)  31. 00 0 32. 00 33. 00 0 33. 00 34. 00 0 35. 00 0 37. 00 0 0 0 0 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00  344, 612, 274 43. 00					344, 612, 274		
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer)  0 32.00 33.00 33.00 34.00 35.00 0 36.00 0 37.00 0 38.00 0 0 40.00 40.00 41.00 0 42.00 70tal deductions (sum of lines 37-41) 43.00		ADD (SPECIFY)		_			
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  33.00 34.00 33.00 34.00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 344,612,274 43.00				-			
34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) 37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 34. 00 0 35. 00 0 0 36. 00 0 37. 00 0 0 0 0 0 0 40. 00 0 41. 00 0 42. 00 344, 612, 274 43. 00				-			
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.00 0 36.00 37.00 0 37.00 0 38.00 0 0 0 40.00 41.00 0 42.00 344,612,274				-			
36.00   Total additions (sum of lines 30-35)   0   36.00   37.00   38.00   39.00   40.00   41.00   42.00   Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer   344,612,274   43.00   36.00   37.00   38.00   38.00   39.00   40.00   41.00   42.00   39.00   40				-			
37. 00 38. 00 39. 00 40. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  37. 00 0 0 38. 00 0 0 40. 00 40. 00 41. 00 42. 00 344, 612, 274 43. 00				0			
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344, 612, 274 43.00					0		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344, 612, 274 43.00		DEDUCT (SPECIFY)		-			
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344, 612, 274 43.00				-			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344, 612, 274 43.00				-			
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344, 612, 274 43.00				_			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 344,612,274 43.00				0			
					0		
to Wkst. G-3, line 4)	43.00		(transfer		344, 612, 274		43.00
		to WKst. G-3, line 4)	l				

	<i></i>	ST HOSPITALS, INC		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0002	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019		narod:
			10 12/31/2019	6/25/2020 8: 0	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, colu	ımn 3, line 28)		1, 318, 733, 744	1.00
2.00	Less contractual allowances and discounts on patient	s' accounts		990, 486, 519	2.00
3.00	Net patient revenues (line 1 minus line 2)			328, 247, 225	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part	II, line 43)		344, 612, 274	4.00
5.00	Net income from service to patients (line 3 minus li	ne 4)		-16, 365, 049	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 258, 591	7. 00
8.00	Revenues from telephone and other miscellaneous comm	nunication services		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies t	o other than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and cante	een		0	
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23. 00
24.00	OTHER INCOME			5, 400, 047	24.00
24. 01	NON OPERATING INCOME			20, 417	24. 01
24. 02	CHANGE IN UNREALIZED GAIN/LOSS			8, 461, 712	24. 02
24. 03	REALIZED GAIN/LOSS ON INVESTMENT SAL			544, 085	
24.04	GAIN/LOSS ON ASSET DISPOSAL			-213, 293	24.04
25.00	Total other income (sum of lines 6-24)			17, 471, 559	25. 00
26.00	Total (line 5 plus line 25)			1, 106, 510	26. 00
27 00	FOUNDATION SALARY			212 70/	1 27 00

0 27.01

213, 794 28. 00 892, 716 29. 00

213, 794

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 FOUNDATION SALARY

27. 01 | FOUNDATION OTHER

Heal th	Financial Systems		METHODIST HOSE	ITALS, INC			In Lieu	of Form CMS-2	2552-10
COST AL	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0002		eriod: com 01/01/2019	Worksheet H-1 Part I	
				HHA CCN:	15-7536			Date/Time Pre 6/25/2020 8:0	
							Home Health	PPS	<u> </u>
			Capital Rela	atod Costs			Agency I		
			Capi tai Kera	area costs					
		Net Expenses	Bl dgs &	Movable	Plant		Transportatio	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation Maintenand		n	(cols. 0-4)	
		(from Wkst.							
		H, col . 10)	1. 00	2.00	3.00		4. 00	4A. 00	
(	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00		4.00	4A. 00	
	Capital Related - Bldg. &	0	0					0	1.00
4	Fixtures Capital Related - Movable	0		C				0	2.00
	Equi pment								
- 1	Plant Operation & Maintenance Transportation	0	0	C	1	0	0	0	3. 00 4. 00
	Administrative and General	872, 905	o	C	1	O	0	872, 905	
-	HHA REIMBURSABLE SERVICES		-1				-1		
	Skilled Nursing Care Physical Therapy	931, 980 472, 299	0	C	1	0	0	931, 980 472, 299	
8. 00	Occupational Therapy	121, 131	ő	C	1	0	0	121, 131	•
4	Speech Pathology	36, 063	O	C		0	0	36, 063	
	Medical Social Services Home Health Aide	2, 552 62, 975	0	C	1	0	0	2, 552 62, 975	10.00 11.00
	Supplies (see instructions)	02, 770	Ö	C	1	0	o o	02, 770	
	Drugs	0	0	C	1	0		0	
	DME HHA NONREI MBURSABLE SERVI CES	0	0	C	1	0	0	0	14.00
	Home Dialysis Aide Services	0	0	C		0	0	0	15.00
	Respiratory Therapy	0	0	C	1	0	0	0	
	Private Duty Nursing Clinic	I 0	0	C	l .	0	0	0	
	Health Promotion Activities	Ö	0	C	l .	O	o	0	
	Day Care Program	0	0	C	1	0	0	0	
- 1	Home Delivered Meals Program Homemaker Service	0	0	C		0	0	0	
	All Others (specify)	0	0	C		0	0	0	23. 00
	Tel emedi ci ne	0	0	C	1	0	0	0	
24.00	Total (sum of lines 1-23)	2, 499, 905 Admi ni strati v	Total (col s.			U <sub>I</sub>	U	2, 499, 905	24.00
		e & General	4A + 5)						
	CENEDAL SEDVICE COST CENTEDS	5. 00	6. 00						
	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &								1.00
	Fixtures								
	Capital Related - Movable Equipment								2. 00
1	Plant Operation & Maintenance								3. 00
	Transportation	070 005							4.00
	Administrative and General HHA REIMBURSABLE SERVICES	872, 905							5.00
6.00	Skilled Nursing Care	500, 019							6. 00
	Physical Therapy Occupational Therapy	253, 394 64, 988	725, 693 186, 119						7. 00 8. 00
4	Speech Pathology	19, 348	186, 119 55, 411						9.00
10. 00	Medical Social Services	1, 369	3, 921						10.00
	Home Health Aide Supplies (see instructions)	33, 787 0	96, 762 0						11. 00 12. 00
	Drugs	0	0						13.00
14. 00	DME	0	0						14.00
	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0						15. 00
	Respiratory Therapy	0	0						16. 00
17. 00	Private Duty Nursing	0	0						17.00
- 1	Clinic Health Promotion Activities	0	0						18. 00 19. 00
	Day Care Program	0	0						20.00
00	Home Delivered Meals Program	l o	o						21.00
21. 00		1	.1						00
21. 00 22. 00	Homemaker Service	0	0						22. 00 23. 00
21. 00 22. 00 23. 00 23. 50		0	0 0 0 2, 499, 905						22. 00 23. 00 23. 50 24. 00

	Florest at Contrar		METHODI OT 1100	SDI TALC LAIG		111	. C. F OHC .	2550 40
	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS	218	METHODIST HOS	Provider C	CN: 15-0002	In Lie Period:	u of Form CMS-2 Worksheet H-1	
0031 7	RECOMPTON THIN STATISTICAL DA	51.5		HHA CCN:	15-7536	From 01/01/2019 To 12/31/2019	Part II	pared:
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportation	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
	1	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	.1			1			
1. 00	Capital Related - Bldg. & Fixtures	0				0		1.00
2. 00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see	l ol	0	l o	i	0		4.00
	instructions)							
5.00	Administrative and General	o	0	0		0 -872, 905	1, 627, 000	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	, , , , , , , ,	
7.00	Physi cal Therapy	0	0	0		0 0	472, 299	7. 00
8.00	Occupational Therapy	0	0	0	1	0	121, 131	
9. 00	Speech Pathology	0	0	0		0	36, 063	
10. 00	Medical Social Services	0	0	0		0	2, 552	
11.00	Home Heal th Ai de	0	0	0	1	0	62, 975	
12.00	Supplies (see instructions)	0	0	0		0	0	
13.00	Drugs	0	0	_	1	0	0	13.00
14. 00	DME	0	0	0		0 0	0	14.00
15 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	ı	0 0	0	15 00
15. 00 16. 00	Respiratory Therapy	0	0			0 0	0	15. 00 16. 00
17. 00	Private Duty Nursing	0	0			0		
18.00	Clinic		0			0		
19. 00	Health Promotion Activities		0			0		19.00
20. 00	Day Care Program		0			0		20.00
21. 00	Home Delivered Meals Program	ا	0	1		0 0	١	21.00
22. 00	Homemaker Service	ا	Ô	1		o o	1 0	22.00
23. 00	All Others (specify)	ا م	n	l o		0 0	1 0	23. 00
23. 50	Tel emedi ci ne	l ol	0		,	o o	l o	23. 50
24. 00	Total (sum of lines 1-23)	o	0	0		0 -872, 905	1, 627, 000	
25.00	Cost To Be Allocated (per	O	0	0		0	872, 905	
	Wasslinkant II 1 Dant IN	1		1	I	1	I	I

0.000000

0. 000000

0.000000

0.000000

0. 536512 26. 00

Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Home Health Agency I CAPI TAL RELATED COSTS DATA ADMITTI NG HHA Trial BLDG & FIXT **EMPLOYEE PURCHASI NG** Cost Center Description Bal ance (1) **BENEFITS** PROCESSI NG RECEIVING AND DEPARTMENT **STORES** 0 1. 00 4.00 5. 01 5. 02 5. 03 1.00 Administrative and General 00 456, 378 0 8, 176 1.00 11, 122 2.00 Skilled Nursing Care 1, 431, 999 2.00 Physical Therapy 725, 693 0 0 3.00 000000000000000000 0 3.00 Occupational Therapy 186, 119 0 0 o 4.00 4.00 0 Speech Pathology 0 5.00 55, 411 0 5.00 0 6.00 Medical Social Services 3, 921 0 0 6.00 7.00 Home Heal th Aide 96, 762 o 7.00 0 0 0 0 0 8 00 Supplies (see instructions) 8 00 0 0 9.00 Drugs C 9.00 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 0 0 0 11.00 Respiratory Therapy 0 12 00 12 00 13.00 Private Duty Nursing 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 0 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 0 18.00 0 18.00 All Others (specify) 0 0 19 00 0 19 00 C 0 19.50 Tel emedi ci ne 0 0 19.50 456, 378 Total (sum of lines 1-19) (2) 2, 499, 905 11, 122 8, 176 20.00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places CASHI ERI NG/AC OPERATION OF LAUNDRY & Cost Center Description Subtotal OTHER A&G PATI ENT COUNTS TRANSPORTATI O PLANT LINEN SERVICE RECEI VABLE 5.05 5.06 7. 00 8.00 5. 04 5A. 04 21, 279 1.00 Administrative and General 496, 955 60, 166 1.00 2.00 Skilled Nursing Care 0 1, 431, 999 173, 370 0 0 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 Physical Therapy 3.00 0 725, 693 87, 859 0 3 00 0 4.00 Occupational Therapy 186, 119 22, 533 4.00 5.00 Speech Pathology 0 55, 411 6, 709 0 5.00 3, 921 0 6.00 Medical Social Services 0 475 0 6.00 0 7.00 Home Health Aide 96, 762 11, 715 7.00 8.00 0 Supplies (see instructions) 8.00 9.00 0 9.00 Drugs 0 0 0 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services 0 C 11.00 12.00 Respiratory Therapy 0 12.00 0 13.00 Private Duty Nursing 0 0 0 13.00 0 0 14.00 Clinic C 14.00 15.00 Health Promotion Activities C 15.00 0 0 0 16.00 Day Care Program 0 0 16.00 0 Home Delivered Meals Program 17.00 0 17.00 0 0 18.00 Homemaker Service C 18.00 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 19.50 21, 279 2, 996, 860 20.00 20 00 Total (sum of lines 1-19) (2) 362, 827 0 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101. (2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

0

0

0

0

C

C

11,624

0

0

0

0

0

0

0

0

0 0

0

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

19.50 20.00

21.00

000

0

0

0

0

0

11.688

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20 00

21.00

Clinic

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101. (2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der Co		Peri od:	Worksheet H-2	
						From 01/01/2019	Part I	
				HHA CCN:	15-7536	To 12/31/2019		pared:
							6/25/2020 8:0	3 am
						Home Health	PPS	
						Agency I		
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		PROGRAM		Resi dents		A&G (see Part	Costs	
				Cost & Post		11)		
				Stepdown		,		
				Adjustments				
		23. 00	24. 00	25. 00	26.00	27. 00	28. 00	
1. 00	Administrative and General	20.00	594, 305	0	594, 30		20.00	1.00
2. 00	Skilled Nursing Care		1, 605, 369	0	1, 605, 36		1, 945, 801	
3. 00	Physical Therapy	٥	813, 552	0	813, 55	· ·	986, 071	1
4. 00	Occupational Therapy	0	208, 652	0	208, 65			
		0		0				
5.00	Speech Pathology	0	62, 120	0	62, 12		75, 293	
6. 00	Medical Social Services	0	4, 396	0	4, 39		5, 328	
7.00	Home Health Aide	0	108, 477	0	108, 47	23, 003		
8.00	Supplies (see instructions)	0	0	0		0	0	
9.00	Drugs	0	0	0		0	0	9.00
10.00	DME	0	0	0		0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	o	ol	0		0 0	0	12.00
13.00	Private Duty Nursing	o	ol	0		0	0	13.00
14.00	Clinic	0	0	0		0	0	14.00
15. 00	Health Promotion Activities	ا	ام	0		0	i n	15.00
16. 00	Day Care Program	١	o o	0		0	l o	16.00
17. 00	Home Delivered Meals Program	0	0	0				17.00
18. 00	Homemaker Service	0	o o	0		0		18.00
		0	U	0		0	0	
19. 00	All Others (specify)	0	0	0		0	0	19.00
19. 50	Tel emedi ci ne	0	O	0		0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	3, 396, 871	0	3, 396, 87		3, 396, 871	
21.00	Unit Cost Multiplier: column					0. 212057		21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	•	. '	'		•			•

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Peri od: Worksheet H-2
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am HHA CCN: 15-7536 Home Health

						Agency I	PPS	
		CAPI TAL				Agency		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
	oost derret bescription	(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	COUNTS	
		(SQUARE TELT)	DEPARTMENT	(MACHI NE	STORES	CHARGES)	RECEI VABLE	
			(GROSS	TIME)	(PURCHASE	CHARGES)	(GROSS	
			SALARI ES)	IIIIL)	REQUISITIONS)		CHARGES)	
		1. 00	4. 00	5. 01	5. 02	5. 03	5. 04	
1. 00	Administrative and General	0	2, 121, 771	0.01				1. 00
2. 00	Skilled Nursing Care	0	2, 121, 771	0	102, 074	3, 330, 312	0, 330, 312	2. 00
	9	0	0	0		0	1	
3.00	Physical Therapy	0	0	0		0	1 -1	3.00
4. 00	Occupational Therapy	0	U	0	1	0	0	4.00
5.00	Speech Pathology	0	U	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	-		0	6.00
7. 00	Home Heal th Ai de	0	0	0	-	_	0	7.00
8. 00	Supplies (see instructions)	0	0	0			-1	8. 00
9. 00	Drugs	0	0	0	1		1 -1	9. 00
10.00	DME	0	0	0		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	1	0	0	11. 00
12. 00	Respi ratory Therapy	0	0	0	0		0	12.00
13.00	Private Duty Nursing	0	0	0	1		0	13.00
14.00	Clinic	0	0	0	0		0	14.00
15. 00	Health Promotion Activities	0	0	0	-		0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18. 00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2, 121, 771	0	102, 874	3, 536, 512	3, 536, 512	20.00
21.00	Total cost to be allocated	0	456, 378	0	11, 122	8, 176	21, 279	21.00
22.00	Unit cost multiplier	0. 000000	0. 215093	0.000000	0. 108113	0. 002312	0. 006017	22.00
							0.000017	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22.00
	Cost Center Description			PATI ENT TRANSPORTATI 0	OPERATION OF PLANT			22.00
	Cost Center Description	Reconciliatio	OTHER A&G	TRANSPORTATION		LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	TRANSPORTATI 0	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio n	OTHER A&G (ACCUM. COST)	TRANSPORTATION N (NUMBER OF TRIPS)	PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	22.00
		Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	
1.00	Administrative and General	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 496, 955	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	1.00
2.00	Administrative and General Skilled Nursing Care	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0	PLANT (SQUARE FEET)  7.00  0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0	HOUSEKEEPI NG (SQUARE FEET)  9.00 0	1.00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05  496, 955 1, 431, 999 725, 693	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET)  7.00 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0	HOUSEKEEPI NG (SQUARE FEET) 9.00	1. 00 2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0	HOUSEKEEPI NG (SQUARE FEET)  9.00 0	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0	HOUSEKEEPI NG (SQUARE FEET)  9.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	SA. 05	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0	9.00  9.00  0 0 0	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	SA. 05	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0	9.00  9.00  0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0	7.00 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	7.00 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 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
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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 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 14.00 15.00
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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	SA. 05  5A. 05  0 0 0 0 0 0 0	OTHER A&G (ACCUM. COST)  5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 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 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	SA. 05  5A. 05  0 0 0 0 0 0 0	5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921 96, 762 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 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 19. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	5A. 05  0 0 0 0 0 0 0 0 0 0	5. 05 496, 955 1, 431, 999 725, 693 186, 119 55, 411 3, 921 96, 762 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	TRANSPORTATION N (NUMBER OF TRIPS)  5.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

Peri od: Worksheet H-2
From 01/01/2019
To 12/31/2019 Date/Time Prepared: 6/25/2020 8:03 am BASIS HHA CCN: 15-7536

							0/23/2020 6.0.	) aiii
						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(PRODUCTI VE	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		SERVED)	HOURS)	N	SUPPLY	REQUIS.)	LI BRARY	
				(DI RECT NURS.	(COSTED		(GROSS	
				HRS. )	REQUIS.)		CHARGES)	
	1	10. 00	11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00	Administrative and General	0	0	0		31, 345	3, 536, 512	1.00
2. 00	Skilled Nursing Care	0	0	0		0	0	2.00
3.00	Physi cal Therapy	0	0	0	1	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	O	0	0	0	0	o	17.00
18.00	Homemaker Service	o	0	0	0	0	o	18.00
19.00	All Others (specify)	o	0	0	0	0	o	19.00
19. 50	Tel emedi ci ne	l ol	0	0	0	0	ol	19.50
20.00	Total (sum of lines 1-19)	o	0	0	0	31, 345	3, 536, 512	20.00
21.00	Total cost to be allocated	l ol	0	0	l 0	13, 872	11, 688	21.00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 003305	
						RESI DENTS		
	Cost Center Description	SOCI AL	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	•							
		SERVI CE	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
		SERVICE (TIME SPENT)			RY & FRINGES (ASSIGNED			
			EDUCATI ON	EDUCATI ON		R PRGM COSTS	PROGRAM	
			EDUCATI ON	EDUCATION (ASSI GNED	(ASSI GNED	R PRGM COSTS (ASSI GNED	PROGRAM (ASSI GNED	
1. 00	Administrative and General	(TIME SPENT)	EDUCATION (TIME SPENT)	EDUCATION (ASSIGNED TIME)	(ASSI GNED TI ME) 21.00	R PRGM COSTS (ASSIGNED TIME)	PROGRAM (ASSI GNED TI ME)	1.00
	1	(TIME SPENT) 17.00	EDUCATION (TIME SPENT)	EDUCATION (ASSIGNED TIME) 17.02	(ASSI GNED TI ME) 21.00	R PRGM COSTS (ASSI GNED TIME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00	
2.00	Skilled Nursing Care	(TIME SPENT)  17.00 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02	(ASSI GNED TI ME) 21. 00 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00	2.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	(TIME SPENT)  17.00 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17.02	(ASSI GNED TI ME) 21. 00 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00	2. 00 3. 00
2. 00 3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	(TIME SPENT)  17.00 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17.02	(ASSI GNED TI ME) 21. 00 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02	(ASSI GNED TI ME) 21. 00 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0	2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02	(ASSI GNED TI ME) 21. 00 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0	2.00 3.00 4.00 5.00 6.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0	(ASSI GNED TI ME) 21. 00 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22. 00 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00	PROGRAM (ASSIGNED TIME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22. 00 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22. 00 0 0 0 0 0 0	PROGRAM (ASSIGNED TIME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22. 00 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME) 17. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
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	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED T1 ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED T1 ME) 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
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	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSIGNED TIME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	17. 00 0 0 0 0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED T1 ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME)  21. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
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 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATI ON (TIME SPENT) 17. 01 2, 202	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSI GNED TI ME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
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 19. 00 19. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (TIME SPENT)  17. 01  2, 202  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME)  21. 00  0  0  0  0  0  0  0  0  0  0  0  0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSIGNED TIME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 19.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (TIME SPENT)  17. 01  2, 202  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSI GNED TI ME)  21. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSIGNED TIME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 19.00 19.50 20.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	17. 00  17. 00  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (TIME SPENT)  17. 01  2, 202  0  0  0  0  0  0  0  0  0  0  0  0	EDUCATION (ASSIGNED TIME)  17. 02  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(ASSIGNED TIME) 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS (ASSI GNED TI ME) 22.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PROGRAM (ASSIGNED TIME) 23.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 19.00

2.00   Physical Therapy   3.00   986,071   0   986,071   5,463   180.50   2.00	Hoal +h	Financial Systems		METHODI ST HOS	DITALS INC		In Lio	u of Form CMS 1	DEE2 10
HINA COR			rs .	METHODIST HOS		CN: 15-0002			
Cost Center Description	ALTOKI	TOWNERT OF TATTENT SERVICE 6031	. 3				From 01/01/2019	Part I Date/Time Pre	pared:
Cost Center Description   From, West.   Facility   Shared   Total HMs   Total Visits   Average Cost   Per Visit   Col. 28. line   Per Visit   Col. 28. line   Per Visit   Col. 28. line   Per Visit   Col. 3 + Col. 4   Per Visit   Col. 4   Per Visit   Col. 3 + Col. 4   Per Visit   Col. 4   Per Visit   Col. 3 + Col. 4   Per Visit   Col.					Titl∈	XVIII			o alli
PART I - COMPUTATION OF LESSER OF AGGREGATE PROCRAW COST. AGGREGATE OF THE PROCRAW LIMITATION COST. OR BENEFICIARY COST. LIMITATION COST. OR SENERICIARY COST. AGGREGATE OF THE PROCRAW LIMITATION COST. OR BENEFICIARY C		Cost Center Description	H-2, Part I,	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (cols	Total Visits	Per Visit (col. 3 ÷	
COST LIMITATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST  OR COST COST, OR COS			0			2 00	4.00		
COST LIMITATION		DART I _ COMPUTATION OF LESSER							
Cost Per Visit Computation   1,945,801   1,945,801   12,254   158.79   1,00   581   164 Mursing Care   2,00   1,945,801   0,986,071   0,986,071   5,463   180,50   2,00			OI MOOKEOMIE	TROOMAIN COST, 1	NOUNEONTE OF T	IL I ROORAW EI	WITHTION COST, C	N DENETTOTAKT	
1.00   Skilled Nursing Care   2.00   1,945,801   1,945,801   12,254   158.79   1,000									
1.00   0ccupational Therapy	1.00		2.00	1, 945, 801		1, 945, 80	01 12, 254	158. 79	1.00
4.00   Speech Pathology   5.00   75,293   75,293   272   276.81   4.00   6.00   6.00   Home Health Alide   7.00   131,480   131,480   131,480   2,368   55.52   6.00   7	2.00	Physi cal Therapy	3.00	986, 071	0	986, 0	71 5, 463	180. 50	2.00
Medical Social Services	3.00	Occupational Therapy	4.00	252, 898	0	252, 89	98 1, 369	184. 73	3.00
	4.00		5.00			75, 29	93 272	276. 81	4.00
Total (sum of lines 1-6)	5.00	Medical Social Services	6. 00	5, 328				177. 60	5.00
Program Visits   Part B   Program Visits   Part B   Part B   Not Subject   Subject Deductibles   Subject Ded	6.00	Home Health Aide	7.00	131, 480		131, 48	30 2, 368	55. 52	6.00
Cost Center Description   Cost Limits   CBSA No. (1)   Part A   Not Subject to beductibles   Subject to beductibles   Color surance   Cost Center Description   Cost Center	7. 00	Total (sum of lines 1-6)		3, 396, 871	0				7.00
Cost Center Description   Cost Limits   CBSA No. (1)   Part A   Not Subject to Deductibles   Colonsurance   Cost Computation						Program Visi	ts		
Cost Center Description   Cost Limits   CBSA No. (1)   Part A   Not Subject to Deductibles   Colonsurance   Cost Computation				1					
Limitation Cost Computation   Skilled Nursing Care   23844   0   3,682   8.00				0004 11 (4)					
Limitation Cost Computation		Cost Center Description	Cost Limits	CBSA No. (1)	Part A				
Skilled Nursing Care   23844   0   3,682   8.00   9,00   10,00   200   3.00   4.00   5.00									
Solution   Skilled Nursing Care   23844   0   3,682   0   0   0   0   0   0   0   0   0									
Limitation Cost Computation   Skilled Nursing Care   23844   0   3,682   8.00   9.00   Physical Therapy   23844   0   1,839   9.00   10.00   0   0   0   0   0   0   0   0   0			0	1 00	2 00			5.00	
Skilled Nursing Care		Limitation Cost Computation	<u> </u>	1.00	2.00	0.00	1. 00	0.00	
9,00   Physical Therapy   23844   0   1,839   0   1,000   1,	8. 00			23844	0	3.68	32		8.00
10. 00	9. 00				-				
11.00   Speech Pathology   23844   0   80   12.00   13.00   14.00   15.00   16.00									
12.00   Medical Social Services   23844   0   723   12.00   13.00   13.00   14.00   10.00   15.00   14.00   15.00   15.00   16.00	11.00				0				
14.00   Total (sum of lines 8-13)   Cost Center Description   From Wkst.   Facility   Costs (from Wkst. H-2   Part I)   Costs (from Port II)   O   1.00   2.00   3.00   4.00   5.00	12.00			23844	l 0		8		12.00
Cost Center Description   From Wkst.   H-2 Part I, col. 28, line   Wkst. H-2, Part I)   Costs (from Part II)   O   1.00   2.00   3.00   4.00   5.00	13.00	Home Health Aide		23844	0	7:	23		13.00
H-2 Part I, col. 28, line   Costs (from Wkst. H-2, Part II)   Dol. 28, line   Part II)   Dol. 200   Dol. 300   Dol. 4.00   Dol. 5.00	14.00	Total (sum of lines 8-13)			0	6, 70	63		14.00
Col. 28, line		Cost Center Description							
Supplies and Drugs Cost Computations				Wkst. H-2,	Costs (from	,		- COI. 4)	
Supplies and Drugs Cost Computations						0.00	4.00	5 00	
15.00   Cost of Medical Supplies   8.00   9.00   0   0   0   0   0   0   0   0   0		Cumpling and Dauga Coat Comput		1.00	2.00	3.00	4.00	5.00	
16.00   Cost of Drugs   9.00   0   0   0   0   0   0   0   0   0	15 00			_		l	0	0.000000	15 00
Program Visits   Cost of Services   Part B   Part B   Not Subject to Deductibles & Coinsurance   C									1
Part B   Part B   Part B   Not Subject to Deductibles & Coinsurance		,				Cost of			
Cost Center Description				_		Servi ces			
To   Deductibles &   Coinsurance   Coinsur									
Deductibles & Coinsurance   Deductibles & Coinsurance   Coinsurance   Deductibles & Coinsurance		Cost Center Description	Part A	,		Part A	,		
Coinsurance   Coinsurance   Coinsurance									
Cost Per Visit Computation					Coinsurance			Coinsurance	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION COST LIMITATION COST LIMITATION COST LIMITATION COST. OR BENEFICIARY COST LIMITATION			4 00		0.00	0.00		11 00	
COST LIMITATION           Cost Per Visit Computation         Cost Per Visit Computation           1.00 Skilled Nursing Care         0         3,682         0         584,665         1.00           2.00 Physical Therapy         0         1,839         0         331,940         2.00           3.00 Occupational Therapy         0         431         0         79,619         3.00           4.00 Speech Pathology         0         80         0         22,145         4.00           5.00 Medical Social Services         0         8         0         1,421         5.00           6.00 Home Health Aide         0         723         0         40,141         6.00		DADT I COMPUTATION OF LESSED							
1.00     Skilled Nursing Care     0     3,682     0     584,665     1.00       2.00     Physical Therapy     0     1,839     0     331,940     2.00       3.00     Occupational Therapy     0     431     0     79,619     3.00       4.00     Speech Pathology     0     80     0     22,145     4.00       5.00     Medical Social Services     0     8     0     1,421     5.00       6.00     Home Health Aide     0     723     0     40,141     6.00		COST LIMITATION	OI AUUREUATE	NOUNAW CUST, I	NOUNEURIE UF II	IL FRUURAW LI	WILLIAM COST, C	A DENETICIARY	
2.00     Physical Therapy     0     1,839     0     331,940     2.00       3.00     Occupational Therapy     0     431     0     79,619     3.00       4.00     Speech Pathology     0     80     0     22,145     4.00       5.00     Medical Social Services     0     8     0     1,421     5.00       6.00     Home Health Aide     0     723     0     40,141     6.00		-					al ==: ::=		
3.00     Occupational Therapy     0     431     0     79,619     3.00       4.00     Speech Pathology     0     80     0     22,145     4.00       5.00     Medical Social Services     0     8     0     1,421     5.00       6.00     Home Health Aide     0     723     0     40,141     6.00	1.00		0				· ·		
4.00     Speech Pathology     0     80     0     22,145     4.00       5.00     Medical Social Services     0     8     0     1,421     5.00       6.00     Home Health Aide     0     723     0     40,141     6.00			0						1
5. 00     Medical Social Services     0     8     0     1,421     5.00       6. 00     Home Health Aide     0     723     0     40,141     6.00			0						
6.00   Home Heal th Ai de   0   723   0   40,141   6.00			0		ł control de la control de				1
6.00   Home Health Aide   0   723   0   40,141   6.00   7.00   Total (sum of lines 1-6)   0   6,763   0   1,059,931   7.00			0		ł .				
7.00									
	7.00	Tiotai (Suiii Oi TTHES 1-0)	ı	0, /63	I	I	U <sub>1</sub> , U59, 931	I	1.00

Provider CDN: 15-0002	Heal th	Financial Systems		METHODIST HOS	SPITALS. INC		In Lie	u of Form CMS-:	2552-10
HHA CCR  15-7536   To   12/37/2019   Date/Time Prepared, 25/33 am   A/25/2020   Sol. 33 am   A/25/2020   Sol. 33 am   A/25/2020   A/25/2			ΓS			CN: 15-0002	Peri od:	Worksheet H-3	
Cost Center Description   6.00   7.00   8.00   9.00   10.00   11.00					HHA CCN:	15-7536		Date/Time Pre	
Cost Center Description   6.00   7.00   8.00   9.00   10.00   11.00					Title	XVIII		PPS	
Limitation Cost Computation   8.00   8.00   9.00		Cost Center Description					Agency		
Skilled Nursing Care   9,00   Pysical Therapy   9,00   10,00   10,00   10,00   Medical Social Services   12,00   11,00   12,00   14,00   Total (sum of lines 8-13)   Program Covered Charges   Cost of Services   14,00   14,00   Cost Center Description   Part A   Part B   Not Subject   Subject to beductibles & Coinsurance			6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
9.00   Physical Therapy   9.00   11.00									
10.00									
11.00   Speech Pathology   11.00   12.00   13.00   14.00   17.00   14.00   14.00   17.00   14.00   17.00   14.00   17.00   17.00   14.00   17.00   14.00   17.00   14.00   17.00   14.00   17.00   14.00   17.00   14.00   17.00   14.00   14.00   14.00   17.00   14.00   1									
12.00   Medical Social Services   12.00   13.00   14.00   10.00   10.00   10.00   10.00   14.00   10.00   10.00   10.00   14.00   10.00   10.00   14.00   10									
13.00   Home Heal th Aide									
14.00   Total (sum of lines 8-13)   Program Covered Charges   Cost of Services   Part B   Not Subject to beductibles & Colnsurance   Coinsurance   Coinsur									
Part B					•				
Part B	11.00	Total (Sam of Titles o 10)	Progr	ram Covered Ch	arges	Cost of			11.00
Cost Center Description					9				
Cost Center Description									
Deductibles & Coinsurance									
Deductibles & Coinsurance		Cost Center Description	Part A	Not Subject		Part A	Not Subject		
Coinsurance									
Supplies and Drugs Cost Computations   Supplies and Drugs Cost Computations					Coi nsurance			Coi nsurance	
Supplies and Drugs Cost Computations			/ 00		0.00	0.00		44.00	
15.00   Cost of Medical Supplies   0   118,496   0   0   0   0   0   0   15.00		Supplies and Drugs Cost Comput		7.00	8.00	9.00	10.00	11.00	
Cost of Drugs	15 00	Cost of Medical Supplies		118 496	1		0 0	0	15.00
Cost Center Description   Total Program   Cost (sum of cols. 9-10)   12.00									
Cost (sum of cols. 9-10)   12.00	.0.00	Cost Center Description	Total Program						10.00
12.00									
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST COST COST COST COST COST COST COST			col s. 9-10)						
Cost Per Visit Computation   1.00   Skilled Nursing Care   584,665   1.00   2.00   Physical Therapy   331,940   2.00   3.00   0ccupational Therapy   79,619   3.00   4.00   Speech Pathology   22,145   4.00   5.00   Medical Social Services   1,421   5.00   6.00   Total (sum of lines 1-6)   1,059,931   7.00   7.00   Cost Center Description   12.00   12.00   12.00   13.00   10.00   0ccupational Therapy   9.00   10.00   0ccupational Therapy   10.00   11.00   Speech Pathology   11.00   12.00   12.00   13.00   13.00   14.00   14.00   14.00   14.00   14.00   15.00									
Cost Per Visit Computation			OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
1.00   Skilled Nursing Care   584, 665   1.00     2.00   Physical Therapy   331, 940   2.00     3.00   Occupational Therapy   79, 619   3.00     4.00   Speech Pathology   22, 145   5.00     5.00   Medical Social Services   1, 421   6.00     7.00   Total (sum of lines 1-6)   1,059, 931   7.00     Cost Center Description   12.00									_
2. 00 Physical Therapy 331, 940 3. 00 Occupational Therapy 79, 619 4. 00 Speech Pathology 22, 145 5. 00 Medical Social Services 1, 421 6. 00 Home Health Aide 40, 141 7. 00 Total (sum of lines 1-6) 1, 059, 931  Cost Center Description 12. 00  Limitation Cost Computation 8. 00 Skilled Nursing Care 9, 00 Physical Therapy 9. 00 10. 00 Occupational Therapy 9. 00 11. 00 Speech Pathology 9. 00 12. 00 Medical Social Services 12. 00 13. 00 Home Health Aide 13. 00	4 00		F04 (/F						1 00
3. 00 Occupational Therapy 79, 619 4. 00 Speech Pathology 22, 145 5. 00 Medical Social Services 1, 421 6. 00 Home Heal th Ai de 40, 141 7. 00 Total (sum of lines 1-6) 1, 059, 931  Cost Center Description 12. 00  Limitation Cost Computation  8. 00 Skilled Nursing Care 9, 00 Physical Therapy 9. 00 10. 00 Occupational Therapy 9. 00 11. 00 Speech Pathology 11. 00 12. 00 Medical Social Services 12. 00 13. 00 Home Heal th Ai de 13. 00		9							
4.00 Speech Pathology 22,145 5.00 Medical Social Services 1,421 6.00 Home Heal th Aide 40,141 7.00 Total (sum of lines 1-6) 1,059,931 7.00  Cost Center Description 12.00  Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.00 10.00 Occupational Therapy 9.00 11.00 Speech Pathology 11.00 Speech Pathology 12.00 Medical Social Services 12.00 13.00 Home Heal th Aide 13.00									
5.00 Medical Social Services 1,421 5.00 6.00 Home Health Aide 40,141 6.00 7.00 Total (sum of lines 1-6) 1,059,931 7.00  Cost Center Description 12.00  Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.00 10.00 Occupational Therapy 10.00 Occupational Therapy 11.00 Speech Pathology 11.00 Speech Pathology 11.00 Medical Social Services 12.00 13.00 Home Health Aide 13.00									
6.00 Home Heal th Ai de 7.00 Total (sum of lines 1-6) 1,059,931 7.00  Cost Center Description 12.00 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.00 Occupational Therapy 9.00 11.00 Speech Pathology 12.00 Medical Social Services 12.00 Home Heal th Ai de 13.00									
7. 00 Total (sum of lines 1-6) 1,059,931 7.00  Cost Center Description 12.00  Limitation Cost Computation 8. 00  Skilled Nursing Care 9. 00  Physical Therapy 9. 00  10. 00 Occupational Therapy 10. 00  Speech Pathology 11. 00  12. 00 Medical Social Services 12. 00  13. 00 Home Health Aide 13. 00		II							
Cost Center Description   12.00									
12.00			.,						
8. 00   Skilled Nursing Care   8. 00   9. 00   Physical Therapy   9. 00   10. 00   Occupational Therapy   10. 00   Speech Pathology   11. 00   Medical Social Services   12. 00   13. 00   Home Health Aide   13. 00   13. 00   14. 00   15.		·	12. 00						
9. 00		Limitation Cost Computation	•						
10. 00       Occupati onal Therapy       10. 00         11. 00       Speech Pathology       11. 00         12. 00       Medi cal Social Services       12. 00         13. 00       Home Health Aide       13. 00		9					·		
11. 00       Speech Pathology       11. 00         12. 00       Medical Social Services       12. 00         13. 00       Home Health Aide       13. 00									
12.00 Medical Social Services 12.00 13.00 Home Health Aide 13.00									
13. 00 Home Heal th Ai de 13. 00									
		II .							
14.00   10tal (sum of lines 8-13)									
	14.00	liotai (sum of lines 8-13)	l						14.00

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 15-0002	Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2019 To 12/31/2019		
				Ti tl e	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	ENTS		
1.00	Physi cal Therapy	66.00	0. 358241	C		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 396530	C		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 317808	C		Ocol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 341883	C	)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 170061	c	)	0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST HOSPI ATION OF HHA REIMBURSEMENT SETTLEMENT	TALS, INC Provider C	CN: 15-0002	Peri od:	eu of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7536	From 01/01/2019 To 12/31/2019	Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	o an
		<b>'</b>	Doub A	Pai	rt B	
			Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
			1.00	Coi nsurance		
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	TOMARY CHARGI	1.00 ES	2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services					
00	Reasonable cost of services (see instructions)			0 0	1	1
00	Total charges			0 0	0	2
00	Customary Charges  Amount actually collected from patients liable for payment for	or services		0 0	0	3
00	on a charge basis (from your records)  Amount that would have been realized from patients liable for					
00	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)				,	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0	0	6
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)			0	0	7
00	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	nlyifline		0	0	8
00	Primary payer amounts			0 (		9
				Part A Servi ces 1.00	Part B Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
	Total reasonable cost (see instructions)			(	1	
. 00	Total PPS Reimbursement - Full Episodes without Outliers			(	1,	
. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				1	
. 00	Total PPS Reimbursement - PEP Episodes					
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	S			8, 590	
00	Total PPS Outlier Reimbursement - PEP Episodes			(	29	
. 00	Total Other Payments			(	0	
.00	DME Payments				0	
00	Oxygen Payments Prosthetic and Orthotic Payments				0	
00	Part B deductibles billed to Medicare patients (exclude coins	surance)			Ö	1
00	Subtotal (sum of lines 10 thru 20 minus line 21)	ŕ		(	1, 011, 081	22
00				(		23
.00	Subtotal (line 22 minus line 23)			C		
. 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0 1, 011, 081	
	Reimbursable bad debts (from your records)				1,011,001	27
. 00	1 · · · · · · · · · · · · · · · · · · ·	instructions	)			28
. 00	Total costs - current cost reporting period (line 26 plus lin	ne 27)		(		
.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				1	
. 50 . 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration				1	30
. 99	Subtotal (see instructions)				1	
. 01	Sequestration adjustment (see instructions)					
. 02	Demonstration payment adjustment amount after sequestration				1	1
2. 00	Interim payments (see instructions)			C		
3.00	Tentative settlement (for contractor use only)	and 22)			1	
	Balance due provider/program (line 31 minus lines 31.01, 32,	and 33)		(	l .	34
. 00	Protested amounts (nonallowable cost report items) in accorda	anco with CM	2 Dub 15 1		0	35

Health Financial Systems	METHODIST HOSPIT	TALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provi der CCN: 15-0002 HHA CCN: 15-7536	Peri od: From 01/01/2019 To 12/31/2019	Worksheet H-5 Date/Time Prepared:
				6/25/2020 8:03 am

Home Health Agency I Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 990, 860 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. 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 3.01 3. 02 0 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 990, 860 0 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) 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) Program to Provider 5.01 O n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5. 52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 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 6.01 0 0 6.02 SETTLEMENT TO PROGRAM 6.02 Total Medicare program liability (see instructions) 990, 859 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor 8. 00

Health Financial Systems	METHODIST I	HOSPITALS, INC	In lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT	III.LIII.GGI GI	Provi der CCN: 15-0002	Peri od: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre 6/25/2020 8:0	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
PART I - FULLY PROSPECTIVE I	ME I HOD				
CAPITAL FEDERAL AMOUNT	!			2 102 //0	1 00
1.00 Capital DRG other than outl 1.01 Model 4 BPCI Capital DRG ot				3, 183, 660 0	1. 00 1. 01
1.01   Model 4 BPCI Capital DRG ot 2.00   Capital DRG outlier payment				74, 956	1
2.00 Capital DRG Outifier payment 2.01 Model 4 BPCI Capital DRG ou				74, 950	2.00
	ed by number of days in the co	est reporting period (see ins	tructions)	205. 07	3.00
4.00 Number of interns & residen		ist reporting period (see ris	tructrons)	203.07	4.00
4	percentage (see instructions)			0. 41	5.00
	adjustment (multiply line 5 b		1 columns 1 and	13, 053	6.00
1. 01) (see instructions)	adjustilierit (ilidi ti pi y i i ile 5 t	by the sum of fittes fand 1.0	i, corumns rand	13, 033	0.00
	patient days to Medicare Par	rt A patient days (Worksheet	E, part A line	8. 39	7. 00
, , ,	ent days to total days (see i	nstructions)		32. 28	8.00
9.00 Sum of Lines 7 and 8	circ days to total days (see i	nstructions)		40. 67	9.00
	share percentage (see instruc	rtions)		8. 59	
11.00 Di sproporti onate share adju		711 0113)		273, 476	
12.00 Total prospective capital p				3, 545, 145	
12. 00   10 tal prospective dapital p	aymorres (eee riner detrens)			5/ 5/ 5/ 1/ 1/5	12.00
				1. 00	
PART II - PAYMENT UNDER REAS	SONABLE COST				
1.00 Program inpatient routine c	apital cost (see instructions	5)		0	1.00
2.00 Program inpatient ancillary	capital cost (see instruction	ons)		0	2.00
3.00 Total inpatient program cap	ital cost (line 1 plus line 2	2)		0	3.00
4.00 Capital cost payment factor	,			0	4.00
5.00   Total inpatient program cap	ital cost (line 3 x line 4)			0	5.00
				1. 00	
PART III - COMPUTATION OF EX					
1.00 Program inpatient capital c	,			0	1.00
	osts for extraordinary circum			0	2.00
	al costs (line 1 minus line 2	2)		0	3. 00
4.00 Applicable exception percen		.,		0. 00	4.00
	to payments (line 3 x line 4	,		0	5.00
, ,	extraordinary circumstances (s	,		0. 00	1
'	num payment level for extraord	dinary circumstances (line 2 :	x line 6)	0	
8.00 Capital minimum payment lev		12 11 . 2		0	8.00
	ts (from Part I, line 12, as		1	0	9.00
	capital minimum payment level			0	10.00
Worksheet L, Part III, line				0	11.00
	inimum payment level to capit			0	12.00
	ent (if line 12 is positive,			0	13.00
(if line 12 is negative, en	pital minimum payment level c ter the amount on this line)		following period	0	
	ating and capital payment (se			0	15.00
	capital costs (see instruction	ons)		0	16.00
17.00 Current year exception offs	a+ amaum+ (aaa ima+mua+iama)			0	17.00